DEPARTMENT OF MEDICINE
DEC 11 1967

THE MISSISSIPPI DOCTOR

VOLUME 8 BOONEVILLE, MISS., SEPTEMBER, 1930 NUMBER 3

THE ARROW AND THE SONG

I shot an arrow into the air,
It fell to earth, I knew not where;
For, so swiftly it flew, the sight
Could not follow it in its flight.

I breathed a song into the air,
It fell to earth, I knew not where;
For who has sight so keen and strong,
That it can follow the flight of song?

Long, long afterward, in an oak
I found the arrow, still unbroke;
And the song, from beginning to end,
I found it again in the heart of a friend.

—Henry W. Longfellow.

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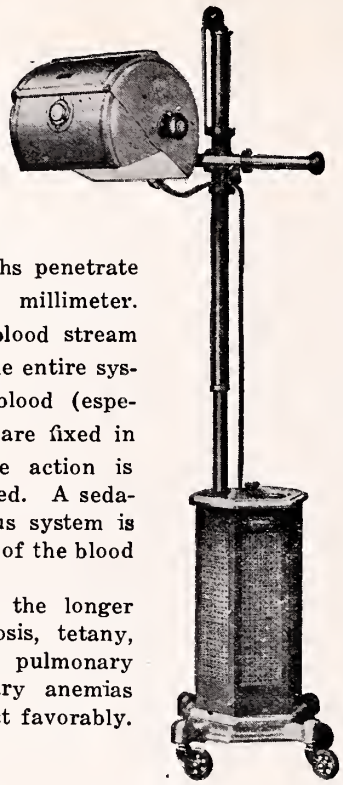

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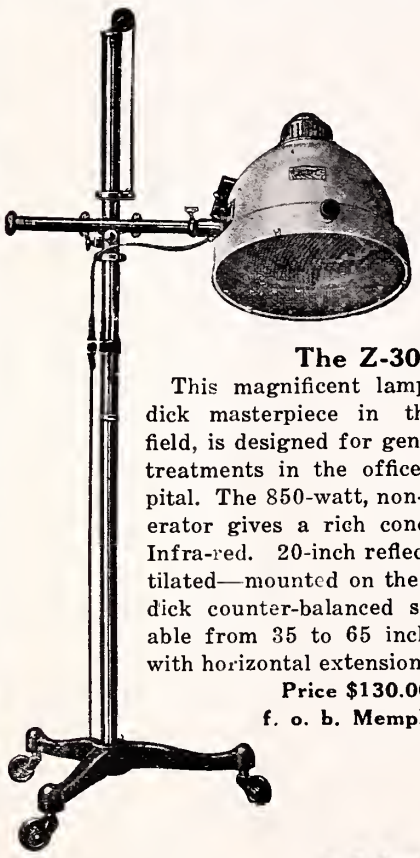

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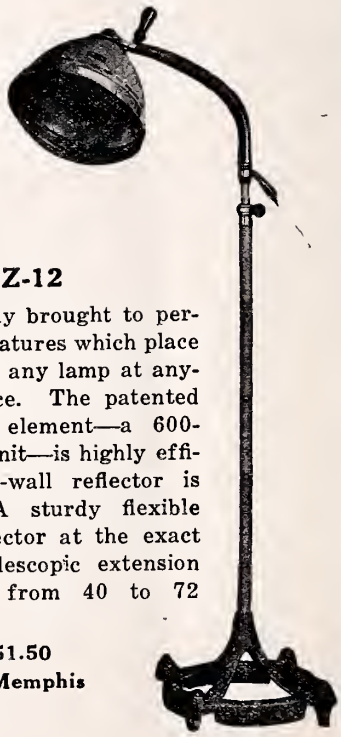

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Booneville, Miss., 114 Main St.

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Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

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The Mississippi Doctor is the property of the Northeast Mississippi Medical Society and has been for about five years. This society has more small hospitals within its limits, perhaps, than any other thirteen adjoining counties in the United States. Quite often it rivals pretty closely the state association in attendance. Not long ago a physician prominent in the American Medical Association remarked that our association is doing more for organized and scientific medicine than any other local society he knew of anywhere. We believe that one of the crying needs of today is to bring modern medicine to the masses at a reasonable price. The Mississippi Doctor has a mission. We hope it is rendering a service. We want to have you as a subscriber. We want you to send us a paper. We want you to report an important and interesting case to us for publication. We will be glad for you to contribute to our editorial columns. Please mail us your check for one dollar and fifty cents and let us send you THE JOURNAL for one full year. Prominent men who take a stack of medical journals are saying that the Mississippi Doctor is one of the most readable and one of the most helpful they receive. Let us send you one of the best for the least price. If your check is not ready send us your name and address and the money later.

The preacher, teacher, and lawyer has a place to do his work, but the doctor has not where to set his bag except as he provides for it himself.

We thank Dr. Henry G. Hill, of Memphis, for his splendid paper on "Fractures."

The third quarterly meeting of the society at Corinth on September 16th was a marked success. It would have made any state association feel proud. Dr. Philpot's paper was in keeping with his past record as an essayist. Dr. Hoye, of Meridian, vice-president of the State Medical Association, presented a good paper on the problems of the local and state associations. This is a fine move on the part of Dr. Howard, president. Dr. Underwood epitomized the fundamental problems of the medical and nursing professions in a very masterful way. Dr. McLester, of Birmingham, gave us the last word on anemias in a very thorough and a very concise manner. The local doctors did themselves very proud in entertaining the society. The banquet was bountiful, was very gracefully served, and the sincere welcome could not be surpassed. We had a number of distinguished visitors whom we were delighted to have. Eight or ten physicians of Memphis were present. They are a clever set that we are pleased to have. Dr. C. D. Mitchell of Jackson was a guest at the meeting and at the banquet. He delivered a short extemporaneous address in his pleasing and masterful manner. We will be glad when the time comes to go back to Corinth. Our next meeting will be held the third Tuesday in December in the cultured and refined town of Aberdeen, the home of our splendid and efficient Secretary.

President E. F. Howard of Vicksburg is on the job for the state association. We believe that great progress is going to be made this year. The association has not really functioned as it might have, the attendance especially has not been what it should. To increase the attendance we must have a strong program to offer and then the membership must be impressed with this and the duty it carries with it. An effort is being made this year at the suggestion of the president to enlist new men in the ranks of essayists. This is a good plan. The guests who are invited should be men of outstanding ability in their respective fields and able to reach the rank and file with their message. We believe that each section should make diligent search for a man who would bring us the very best in the form of a symposium. The state association needs some funds to defray the expense of some of the men whom we would like to have, whom we need, some men who are all time professors and who do not have so much funds for expenses for the number of calls they have. Where shall we receive this? It is easy enough. The Tri-States Medical Association held at the Peabody Hotel in Memphis each year is the best in the United States, offers more for the time, with the possible exception of one. The exhibitors have played a big part in making it what it is. In paying for space they pay the expenses of the essayists, or a large part of it. They talk and advertise it. The average man in the small town needs to see what the exhibitor has about as much as he does to hear the papers. Often times they teach him more. There should be the most friendly relation between the exhibitor and the profession. Each one needs the other. They help to make other associations, why should they not help us? Let us use the potential power more fully in the future than we have in the past to further vitalize the association.

Dr. N. B. Marsh, of Ripley, recently passed to his reward. He was sixty-nine years of age and he had been in the harness as a general practitioner for fifty years. The greater part of this time he practiced in the northern part of Tippah county. For the last few years he had been in Ripley associated with his son, Dr. Marlin. Dr. Bruce Marsh, as he was so well known, was a man of fine native ability. He was a practitioner who had good success. He gave the people good service. He was untiring,—until recently did not know the limit of his endurance. He had good medical judgment. He had plenty of poise. He loved the work. He will be greatly missed. We offer our sincere sympathy to the bereaved family and friends.

We are glad to have a word from our state president, Dr. E. F. Howard, of Vicksburg, who is working like a Trojan to make our next meeting the best in the history of our State Medical ssociation.

More than forty physicians have died in Mississippi this year up to date. This is a high casualty list. About half of these died of heart trouble. This emphasizes the importance of annual or biannual examinations. It also indicates that physicians are working under too high pressure. What is the reason? The physician has a big heart. He loves to relieve suffering humanity. He is working hard to keep abreast with the progress of medicine. He is burdened with too much charity work and too many poor paymasters.

Be sure to read the eulogy to the "Doctor's Wife" by Mrs. T. B. Holloman, of Itta Bena, Miss. This should have been said long ago. Honor to whom honor is due should have been meted out long ago. No one has done greater, nobler, and more unselfish deeds than the doctor's wife; no one thus far has received less praise. She gives without receiving; she waits without murmuring; she endures all and inspires to the end. She is the ministering angel to all, the power behind the throne to the "soldier" who lives his life on the firing line, waging a war against human suffering.

Many of the laity are bemoaning the passing of the "family physician." No nobler character ever lived; no one who has been a greater benefactor to human society; no one so wise in council; none so unselfish in service. But when a good man is taken another is raised up in his place. Instead of the family physician who verily believed he would be rewarded for the strength of his pills and the multiplicity of same, we are soon to have the general practitioner, worthy, well qualified in modern medicine, and versatile in prevention. He will be versed in all the medicine needed in this age of prevention, and surgically qualified to clip an appendix, do a gall bladder, pull tonsils, perform a hysterectomy, and repair a perineum. Medically and surgically speaking, the people will be safer and financially more secure.

Our hats are off to Clay county, which has a membership of one hundred per cent. Prentiss is close in behind with ninety. Mr. Clay, we will soon be up with you unless you pass the hundred mark. But before you we stand at attention until this is accomplished.

In our next issue we will publish a paper on "Enriching Human Life With Color." You will profit by this paper. Your wife will enjoy it.

Goiter Prevention and Thyroid Protection is a new book just off the press, and is published by F. A. Davis Company of Philadelphia. The author is Israel Bram, Medical Director of Bram Goiter Institute. This is a most readable book. It puts everything in clear, simple language so that the average practitioner may understand and may apply the measures sug-

(Continued on Page Sixteen)

FRACTURES

HENRY G. HILL, M.D.,
Memphis, Tenn.

In offering this contribution it shall be my purpose to bring to the attention of the general practitioners and general surgeons some points in the management of the more common injuries which I hope will be helpful.

The subject which your managing editor asked me to write on is one of great importance but by far too broad to do more than suggest a few ideas that my experience prompts me to believe worth while, and to present to the readers some illustrations of a number of severe cases which have come under my observation.

The general practitioner will always be called upon not only to render first aid, but to treat a large per cent of acute fractures. His resourcefulness, good judgment and "horse sense" are drawn upon in this particular branch of his practice probably more than in his other work. Notwithstanding the lack of facilities, well-equipped hospitals and complicated apparatus, the same standard of treatment and the same quality of results as obtained in the best hospitals, are demanded of him by the public as well as the courts.

There is no standardized method of treating fractures; there is no standardized apparatus. Each case differs in some respects from the other; the injury is sustained in a different manner and under different circumstances; again, the degree of severity will vary. Each case is a case unto itself. However, there are certain fundamental principles underlying the treatment of fractures which are essential and should be familiar to all practitioners of medicine.

Primary treatment or first aid is very important. If a patient is seen on the roadside in a state of severe shock with a fracture of the thigh and a compound fracture of both bones of the leg, what should be done. In my opinion, the wound should be hurriedly cleansed and dressed, an attempt made to reduce the fractures and the limbs splinted, "Splint 'em where they lie." Make them as comfortable as possible; administer other indicated general treatment, then transport them. The idea I wish to convey is, never neglect the fracture on account of the patient's general condition. Do not allow a fractured extremity to dangle while transporting a patient; avoid unnecessary manipulation.

Secondary Treatment. Elevate the injured part as soon as it is practical to do so, especially where the soft parts have been severely injured. Swelling and subsequent infection will be reduced to a minimum by early reduction of the fracture and elevation of the injured parts. Reduction of the fragments should be as complete as the individual case requires. Further attempts at reduction should be made as soon as the need is recognized. Decide in each case the problems presented and select apparatus accordingly. The value of any apparatus is of less importance than the skill with which it is used. Roentgen ray examination should be made as early as possible; fluroscopic control if intelligently carried out, is worth while in appropriate cases.

Restoration of function is our goal. This we can expect in a large per cent of cases provided we stick to the fundamental principles which govern the treatment of every fracture regardless of whether it be an oblique fracture in the distant phalanx or the little finger, or a com-

A B C

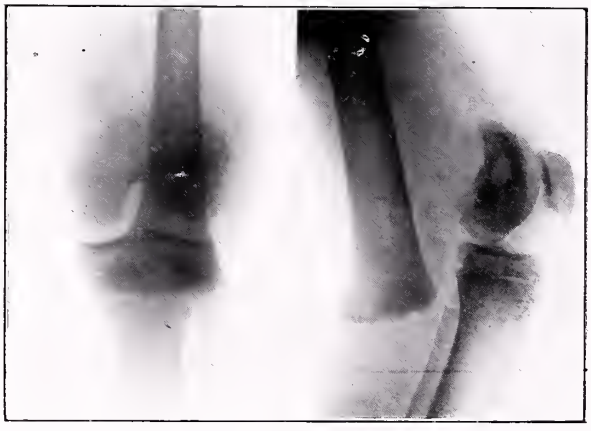
Fig. 1
(a) Fracture middle third of humerus of 5 months' duration, with wide separation of fragments and non union. (b) X-ray made 6 months after bone graft operation (note graft bridging fracture). (c) 3 months after operation, union practically complete.

Fig. 2
Same as in Fig. 1. Photograph made three months after bone graft operation.

minuted one in the hip joint, namely reduction of deformity and proper immobilization of the fragments until union takes place.

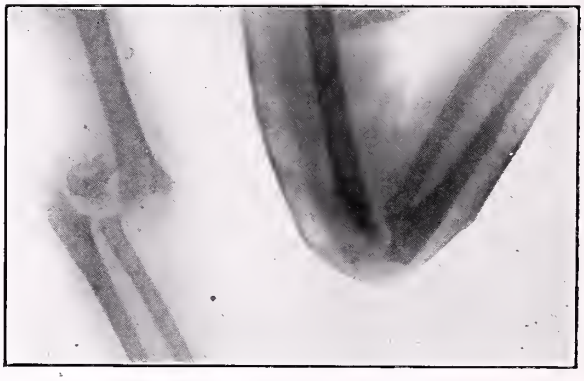
Deformity may result from allowing the fragments to angulate as well as from improper apposition. I have seen on several occasions, the surgeon very much chagrined to find that he had gotten a crooked leg or arm, after the X-ray had shown the fragments to be in perfect apposition. It matters little what method is used to set a fracture, or the type of splint selected to immobilize the fragments. If the deformity is reduced, the fragments immobilized and the soft tissues protected, we can expect function to be restored. Primarily, we must not be content until the injured extremity compares favorably to the normal. Measurements should be accurately made and compared. Contour and muscle power should be taken into consideration. Innervation, blood supply, and joint motion must always be taken care of. We should also know the period necessary to expect union in the various types of fractures, at different ages, under favorable as well as unfavorable conditions.

Fig. 5
Skeletal traction used in reducing fracture to avoid undue strain on ligaments of knee. Caliper points incorporated in cast and removed after four or five days.



A B

Fig. 3
Epiphyseal separation lower femoral epiphysis with marked separation of fragments. (a) Anterior posterior X-ray view, and (b) lateral view.



A B

Fig. 6
(a) Roentgenogram of supercondylar fracture of humerus in child four years of age. (b) Roentgenogram after reduction, with arm in Jones position (acute flexion).

A B

Fig. 4
(a) Anterior posterior and (b) lateral X-ray views of same case, Fig. 3, after reduction had been accomplished by insertion of calipers into femoral condyles and traction on calipers.

There are a few rules which it is well to remember pertaining to the treatment of fractures in the extremities with reference to the most desirable position for immobilization. It is advisable to immobilize those occurring about or extending into the elbow joint, with the forearm acutely flexed. For fractures of the shoulder, abduction of the arm usually gives best alignment. The thigh should be fixed in abduction if we expect to immobilize the fragments in cases of fracture of the hip joint. The leg should be kept straight and the foot dorsoflexed in treating injuries about the knee or ankle joint.

The treatment of compound fractures presents two problems. First, the prevention of infection developing within the wound; second, the reduction and splinting of the fragments. For the purpose of discussion, it is convenient to consider these separately, however, actually

both must be treated simultaneously. If the wound is successfully treated and infection fails to develop primarily, the injury becomes a simple fracture and the problem of splinting is greatly simplified. If attention is directed to the wound only in an effort to suppress or prevent infection and the fracture is neglected, results are almost uniformly disastrous. It is absolutely conclusive that imperfect splinting and improper fixation favors development as well as the continuation of wound infection.

Bone offers but slight resistance to infection and for this reason septic processes easily invade the bone when severe infection develops in the wound. Osteomyelitis is a serious complication and may last for years if once established. Non-union, shortening from loss of bone substance, angulation, as well as loss of muscle function with atrophy, can be expected once a chronic osteomyelitis occurs. Local influences within the wound and the type of infection are important factors in determining the fact of the invading organism provided the extremity is efficiently splinted after the fragments are reduced and steps taken to minimize swelling. When the fragments are not reduced or immobilized the tissues become oedematous and less resistant to the infection. Since it is impossible in a single article to enumerate all the do's and don'ts in connection with the management of compound fractures, it will be necessary to content myself with summarizing the conservative treatment, as follows:

1. Proper first aid and transporting.
2. General condition of patient. Hemorrhage, pain and shock.
3. Reduction and immobilization of fragments at the earliest possible moment is of inestimable importance.
4. All compound fractures are potentially infected and must be considered as such.

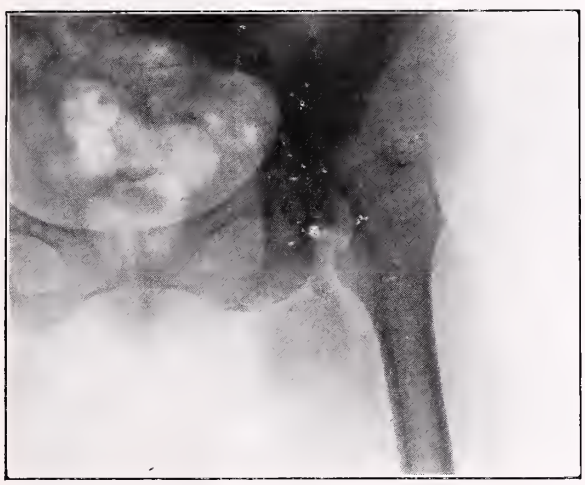


Fig. 7
Central fracture neck of femur with over-riding fragments and eversion of shaft.

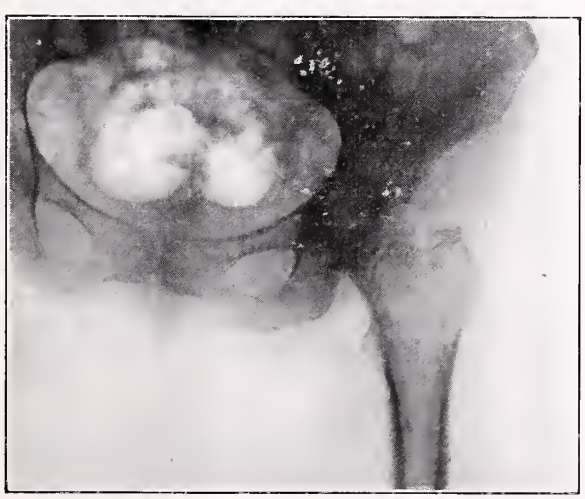


Fig. 8
Same as Fig. 6. Roentgenogram made six months after injury showing union with fragments in good position. This patient was treated by the Whitman's abduction method.

Fig. 9
Multiple fractures of pelvis and fracture upper third of femur with wide separatoin of fragments.

Fig. 10
Fracture of patella with wide separation of fragments.

5. The injured extremity should always be elevated well above the body level for several days after injury. An immunizing dose of antitetanic serum should be given, as a rule.
6. (General anesthetic should be employed in a large per cent of cases.)
7. Never should the fracture be considered secondary and left unsplinted or diseregarded, regardless of the amount of destruction there has been to the soft tissues. Shock as well as infection is increased by the surgeon's failure to direct his attention to the patient's local condition.
8. Attempt to sterilize wound with Dakin's or Hychlorite solution.
9. Avoid displacing or moving fragments during dressing.

OPEN METHOD OR RADICAL TREATMENT

It is generally agreed that open reduction is the treatment of last resort and should be undertaken only by a surgeon familiar with the hazards of bone surgery. There are, however, some fractures best treated by the open method; otherwise the surgeon must be satisfied with permanent deformity. Post-operative infection, of course, is a tragedy and should be a very rare exception. The operation should not be undertaken in a hospital that is not up to standard in every respect, and except in certain cases which will be discussed later, should be postponed for a week or ten days after injury to allow the soft tissues to return to more nearly normal.

We do not hesitate to operate for vicious union—why, then, should we not operate for

Fig. 11
Same as Fig. 9, after reduction of fracture by open operation.

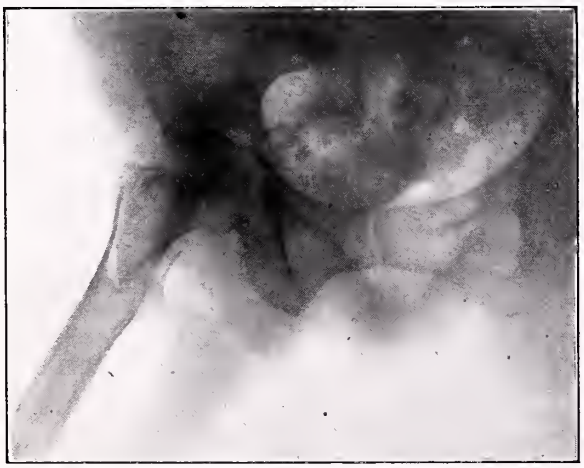


Fig. 12
Intertrochanteric fracture of femur with very little shortening but considerable eversion of shaft.

Fig. 13
Same as Fig. 12, after reduction and application of plaster cast

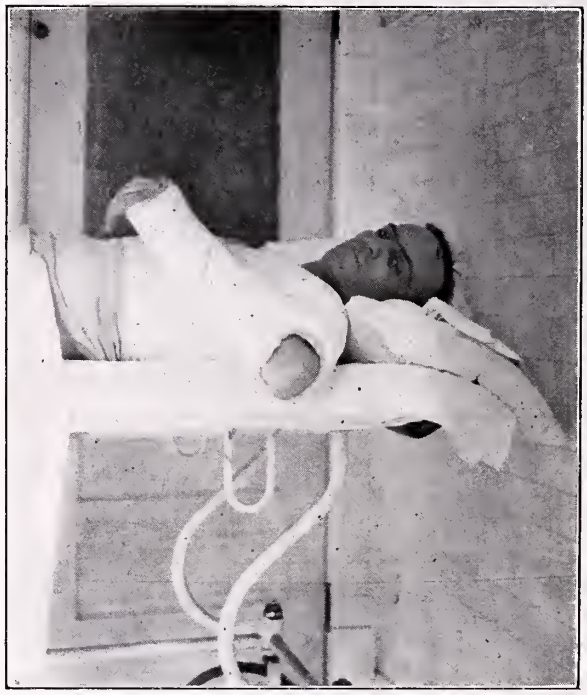


Fig. 14
Photograph of patient wearing plaster-of-paris abduction cast used in the treatment of fractures of the humerus. This is found to be a very comfortable dressing and a most efficient splint.

Fig. 15
Deformity resulting from a fracture of both bones of the forearm with union in vicious position.

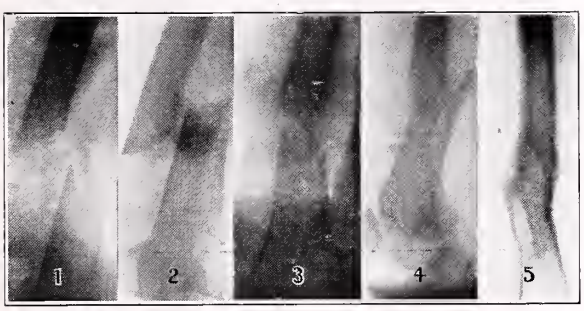


Fig. 16
1 and 2 compound comminuted fracture lower third shaft of femur treated by skeletal traction on Balkin frame. 3 and 4 X-ray four months later. 5, results one year after injury.

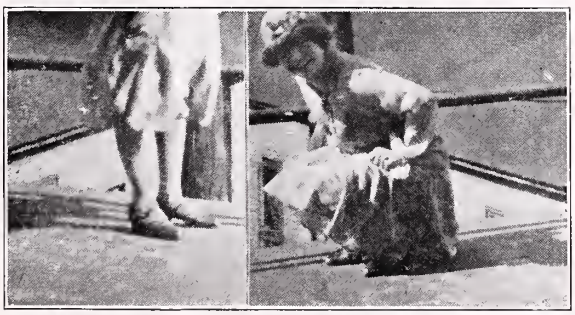


Fig. 17
Same as Fig. 16. Photographs one year after injury. No shortening or stiffness in knee joint.

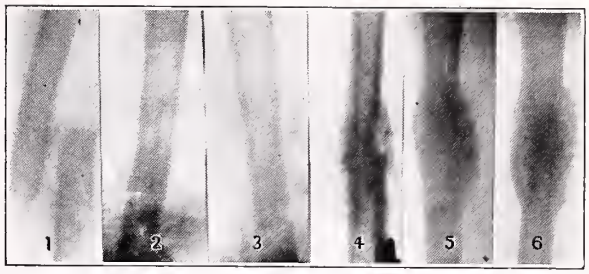


Fig. 18
1, transverse fracture middle third shaft of femur with union in vicious position. Treated by open reduction with inlay bone graft operation. 2 and 3, anterior-posterior and lateral views three months after operation. 4, Roentgenogram nine months post-operative showing abundance of callous surrounding fracture. 5 and 6, anterior-posterior and lateral views at the end of two years.

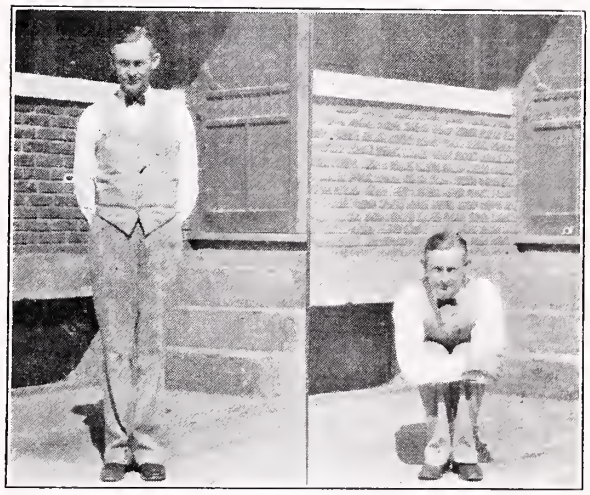


Fig. 19
Photographs two years after operation.
Same as Fig. 18.

Fig. 20
Pseud-arthrosis upper third shaft of femur five years after injury, improperly treated by Buck's extension followed by cast.

vicious fragments? Limitation of joint motion, ankylosis, atrophy of the cartilage does not follow open reduction unless the joint is injured at operation, or has been injured previously, in the absence of infection. The autogenous bone graft meets all requirements as an internal splint. Wire, nails, screws, plates and other foreign materials should not be used to fix fragments. Unfavorable results occur in too great a percentage of cases to warrant the further use of same.

Among the first indications for operative interference is the cleansing of the wound in compound fractures. The debridement operation so extensively practiced and advocated during the recent war should be done diligently, always considering the ultimate functional results. Under general anesthesia all foreign ma-

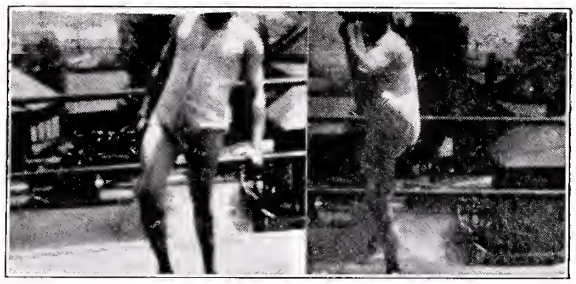
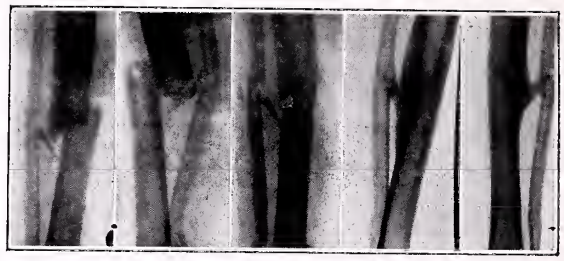


Fig. 21
Same as Fig. 20, showing marked shortening—two inches without weight and five and one-half inches upon weight bearing. Patient walks with an elastic limp and is able to carry foot of injured leg to back of neck. Loses very little time from work, but suffers considerable discomfort after strenuous day.

A B C
Fig. 22
(a) and (b) anterior-posterior and lateral views of old compound fracture with typical non-union nine months after injury. Soft tissues entirely healed. (c) lateral view after operation, showing graft in place.

Fig. 23
Photograph one year after operation.



A B C D E
Fig. 24
(a) and (b) anterior-posterior and lateral views compound fracture tibia and fibula immediately after injury, soft tissue very extensive. (c) anterior-posterior through cast three weeks after bone graft operation. (d) and (e) anterior-posterior and lateral views one year after operation. Note comminution causing union between tibia and fibula.

Fig. 25
Same as Fig. 24. Photograph six months after operation (right leg).

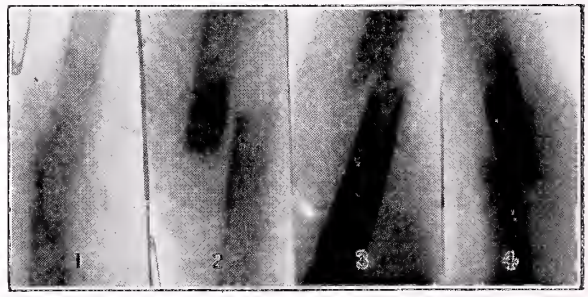


Fig. 26
1 and 2, simple transverse fracture through middle third of shaft of femur in patient sixty-one years of age. Treated by immediate reduction and fixation in plaster cast. 3 and 4, fragments locked. Functional results good in this case even though only forty per cent approximation was obtained.

terials should be removed by thorough mechanical cleansing, free fragments of bone which are completely detached removed and all known

Fig. 27
Same as Fig. 26. Photograph one year after injury.

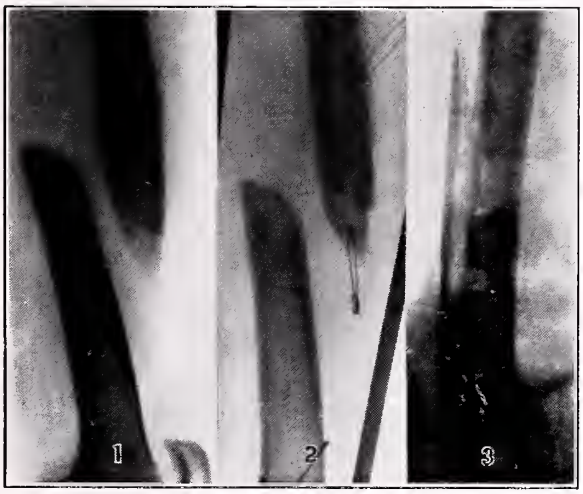


Fig. 28
1, fracture shaft of femur with marked displacement of fragments three months after injury. 2, same with traction applied. 3, Roentgenogram showing only bone graft in place two months after operation.

Fig. 29
Anterior-posterior and lateral views of old gunshot fracture tibia and fibula with angulation of fragments and non-union of tibia.

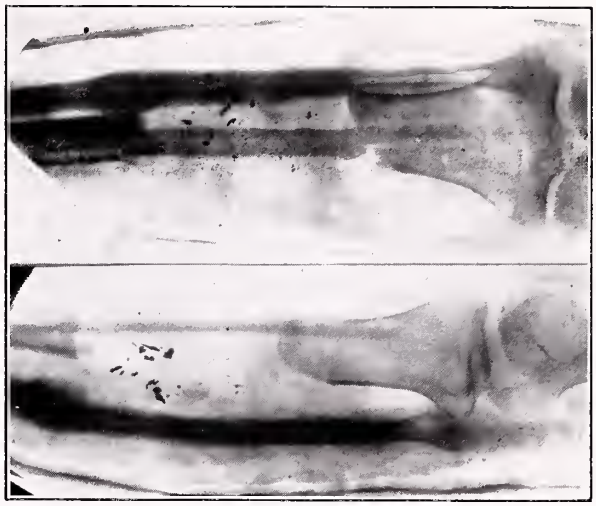


Fig. 30
Same as Fig. 29 after all sclerosed bone has been removed and autogenous bone graft inserted across gap.

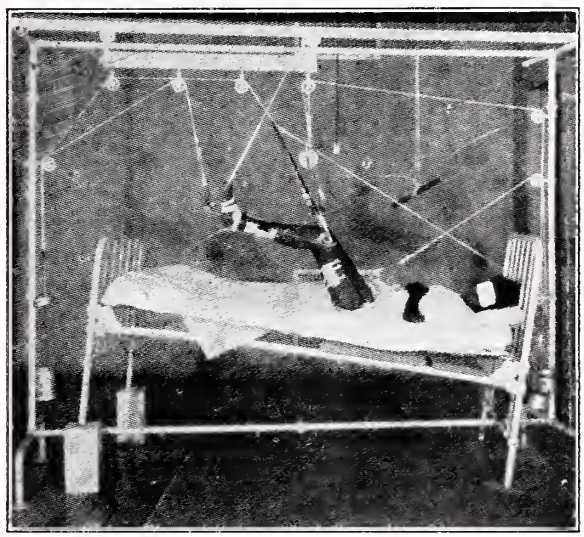


Fig. 31
Method of treating fracture of shaft of femur by direct skeletal traction.

devitalized tissues carefully dissected away. The wound is closed with the fewest number of loosely tied silk worm gut sutures; covering if possible all exposed bone. In extensive soft tissue injuries, a small rubber tissue drain or a wick of vaselinized iodoform gauze may be placed in the wound, being careful not to allow them to come in contact with the bone, as a pressure necrosis may result from prolonged contact with even the softest rubber.

In civilian life ultra radical surgery should be discouraged in the treatment of compound fractures. The bold surgeon who dissects away much soft tissue often leaves a permanently crippled extremity that is useless to the owner. Never should any form of internal fixation be attempted primarily. It is permissible to reduce the fragments instrumentally through the compound opening when necessary, if the bone is

already exposed, but it is unwise to cut down on a covered fragment for the purpose of reduction in the presence of an infected wound.

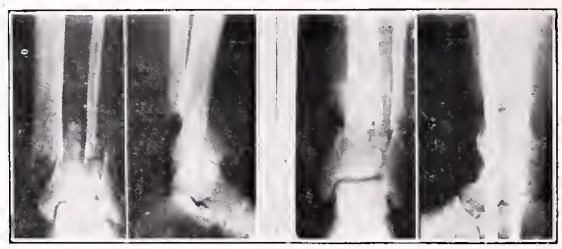
A B C D E

Fig. 32
(a) and (b) anterior-posterior and lateral views of multiple fracture of forearm immediately after injury. Much destruction of soft tissues. Wounds healed with non-union of all fractures. (c) anterior-posterior view made through cast five weeks after bone graft operation. (d) and (e) anterior-posterior and lateral views nine months after operation. Firm union of all fractures.

Fig. 33
Same as Fig. 32. Photograph of arm nine months after operation.

Fig. 34
Marked knock-knee deformity, right leg, following fracture of the shaft of the femur with angulation of fragments.

Fig. 35
Same patient as Fig. 34. Correction of deformity by open osteotomy at site of old fracture with correction of angulation.



A B C D

Fig. 36
Compound fracture tibia and fibula just above ankle. (a) and (b) before reduction. (c) and (d) after reduction, resulting in primary union of fractures.

Fig. 37
Note absorption of bone and non-union following fixation of fragments with wire.

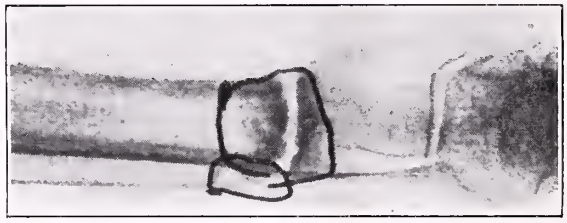


Fig. 38
Showing inefficiency of foreign materials in treating fractures. All wire removed and bone graft done, resulting in firm bony union.

SKELETAL TRACTION

An operative procedure which has proven very satisfactory in my practice is that of reduction of certain fractures by direct skeletal traction, by the use of calipers. The method has been described in detail and space will not permit a lengthy discussion in this article.

Operative procedures on simple fractures or secondary operations on compound fractures (after the soft tissue wound has entirely healed), should be limited to those cases in which it is impossible to secure and maintain a satisfactory reduction by bloodless manipulation. In many cases the fragments can be held in satisfactory position by external splinting after open reduction when the fragments are properly locked. Should more internal fixation be necessary an autogenous bone graft will best serve this purpose.

Perhaps the most difficult decision which the surgeon has to make in connection with the treatment of fractures is that of amputation. With extensive destruction of soft tissues, se-

vere comminution of fragments and severance of the important nerves and blood vessels, little else can be done. Amputation is advisable when the injury has been so severe that recovery with useful function is unlikely, even if healing of the soft parts and bony union can be expected, or when the life of the patient is endangered by virulent infection. Greater risks are justifiable in attempting to save extremities of young people. Also, in attempting to save the upper extremities.

The importance of securing a painless, weight-bearing stump in the lower extremities should never be overlooked. The scar should be so placed as not to be exposed to presure in the socket of the artificial limb. The soft tissue over the end of the bone should be freely movable, but not redundant. In the presence of infection long flaps are especially contraindicated, because of the lowered resistance following impairment of circulation. The so-called flapless amputation is sometimes necessary as a primary operation for the virulent infection.

After care of the stump is very important. Errors in allowing the stump to contract frequently go unnoticed until an effort is made to fit an artificial appliance. Should amputation be decided upon the future application of an artificial appliance should be considered in shaping the stump, and the value of proper care cannot be over stressed.

UTERINE HEMORRAGE

By
V. B. PHILPOT, M.D., F.A.C.S.,
Houston, Mississippi

Mr. Chairman, and Fellow Members of the Northeast Mississippi Thirteen Counties Medical Society:

I should apologize for selecting as a subject only a symptom, but since this symptom is such an important one in so many different diseases of the uterus and its appendicles, I feel that in itself, it is a very important subject.

In studying uterine hemorrhage it is absolutely necessary to be familiar with the physical appearances; namely: size, shape, consistency, and position of the normal uterus; and to be able to elicit to some extent at least the abnormal conditions from a symptomatic and physical standpoint in order to detect the cause of the hemorrhage. And may I say in this connection that in no group of diseases is a careful history taking and physical examination more important, even if it be necessary to give an anaesthetic in making a complete physical examination.

Uterine hemorrhage may be divided into two main groups: those dependent on recent pregnancy and those independent of recent pregnancy. Those dependent on recent pregnancy occur with premature separation of the placenta, retained membranes, hydatidiform mole, chorio-epithelioma, tubal pregnancy, and pregnancy in one horn of a biornate uterus. I shall limit my discussion to those independent of recent pregnancy. Of these I shall mention (1) hemorrhage due to constitutional condition, such as cases of haemophilia and various other forms of blood conditions. For this form of hemorrhage the remedies are entirely medical and dependent on the exact nature of the blood disease producing it.

(2) The next form of hemorrhage independent of recent pregnancy is benign changes in the mucous membrane of the cervix and body of the uterus. Included in these are cervical polypi, or polypi of the endometrium, blocking of the cervical canal due either to constriction of the cervix, endo-cervicitis or endo-metritis accompanied by more or less displacement of the body of the uterus. It is very obvious that a hemorrhage is very easy to occur from either of these conditions as a result of irritation to the mucosa.

The third cause of uterine hemorrhage occurring independent of pregnancy is that due to the presence of uterine tumors such as myomas, adenomyomas and sarcomas. Of these, myomas, usually termed as fibroids, are by far the most common. The amount of hemorrhage produced by such tumors is dependent on their progress or growth toward the endometrium. A very small fibroid in contact with the mucous membrane will cause considerable hemorrhage, while a larger subserous fibroid may produce little or no hemorrhage. Adenomyomas of the uterus, as well as sarcomas, are relatively rare. However, I had one case very recently in a doctor's wife. A small submucous protusion from the internal os was extracted with a tonsil snare and sent to a pathologist who reported "round cell sarcomas." I had no idea at the time I was extracting this small tumor that it was of a malignant character. It only reminds us of the necessity of making, or having made, microscopical examinations of all specimens.

A fourth form of uterine hemorrhage is due to hyperplasia of endometrium, or exfoliative endometritis. This form is rare. I have only seen three cases, all of them were in young girls from 14 to 17 years old, notwithstanding the fact that this condition is usually noticed during the child-bearing period. Hemorrhage in such cases are at times exceedingly severe and prolonged. One case I have in mind had bled until she was almost exsanguinated.

Another and fifth variety of uterine hemorrhage that I shall mention is due to a disease of the adnexa; namely: tubes and ovaries. One cause of hemorrhage, as we all know, is purulent salpingitis. This is sometimes confused with octopic pregnancy, which I shall only mention at this time. A differential diagnosis in such cases can at times only be made by examining the scrapings from the uterus. Should we find decidua present, we know the case is one of octopic pregnancy. Of course other signs and symptoms of inflammation will assist us in the diagnosis of pyosalpinx. Inflammatory diseases of the ovaries are usually secondary to salpingitis; and what has been said regarding salpingitis applies to ovaritis. A large ovarian cyst, however, frequently causes consid-

erable bleeding of the uterus, but as a rule can easily be diagnosed by physical examination.

Now the last and most importan cause of uterine hemorrhage is carcinoma of the cervix or body of the uterus. Carcinoma of the cervix in advanced stages is easily recognized as a friable growth, bleeding very easily to the touch ,and in most advanced stages has a crater lke appearance. At the beginning a cancer of the cervix is not so easily diagnosed microscopically from an ulcer. The chief point in the diagnosis is intermittent hemorrhage between the menstrual periods. The patient may only notice a very slight show, and no pain. Upon vaginal examination we notice an ulcer; it may be very insignificant, but usually bleeds easily. It is only in such cases that we have a curable state. Now the question arises as to section. No less authority than Bloodgood advises against biopsy previous to surgical interference, but rather insists on all suspected lesions being removed in toto before pathological examinations of the specimens are made. Other equally as good men: Deaver, for instance, of Philadelphia, Pa., advocates section on all suspected cases previous to radical surgery. In some of the larger clinics, especially the Mayo Clinic, patients are prepared for surgical interference, anaesthetized, frozen sections are made of a section of all suspected tissue and if malignancy is found, a radical operation is done at the time. Those of us in smaller institutions are of course unable to do this. In all probability the best way for us to proceed, for instance in a suspected cancer of the cervix, is to make a section; follow the section by the use of radium and deep x-ray therapy while the specimen is being examined. Cancer of the body of the uterus in the early stages can only be diagnosed by the scrapings.

The main point to emphasize in carcinoma or adenocarcinoma of the cervix or body of the uterus is that the outcome of the treatment depends entirely on the early diagnosis of such conditions. In the treatment of these conditions opinions differ as to radical surgery and radiation It is our plan in early cancer to combine the two; in other words, a series of deep x-ray or radium treatments previous to the operation; a radical operation followed again by radiation. Now the treatment of non-malignant tumors of the uterus in our way of thinking would best be treated surgically, although the radiologist would give us a great deal of evidence favorable to radiation. This can be said of radiation, in the hands of an experienced man, there is less danger in the treatment itself, although the surgical mortality in non-malignant tumors of the uterus or ovaries is practically nil in the average patient with even a fair constitution. Personally I would prefer sending a bad surgical risk to the radiologist, otherwise I would treat them surgically.

Hemorrhage as a result of diseases of the adnexa are of course best treated surgically. We are opposed, however, to operating on pyosalpinx in the early stages. We prefer to wait until they "cool off" or until the temperature has been normal for at least four to six weeks. Large ovarian cysts of course should be removed. In this connection may I state that the most conservative surgical procedure in dealing with the ovaries is preferable.

Now in the treatment of hemorrhage due to benign changes in the mucous membrane of the cervix or body of the uterus as a result of polypi, hyperplasia of the endometrium; ulceration of the cervix; constriction of the cervix; displacement of the uterus; the chief procedure is to remove the cause. It is in such conditions as these that we can get such wonderful results with a very small amount of surgical interference; removing the polypus, amputating and dilating the ulcerated and constricted cervices; repairing lacerations of the perineum; and occasionally curetting the uterus. In my opinion there are a large number of women in this class that are suffering a great deal with what they consider painful, profused and prolonged menstruation; having one or more of the defects just mentioned and who are going through life without a complete examination; believing their conditions to be one of natural occurrence and spending much money for patent medicines with only temporary relief. I fear also that we doctors are more or less careless in our examinations of these patients. Some of us are prone to give them prescriptions containing some uterine tonic or sedative instead of advising a careful examination to locate the cause of their menstrual disturbances. We must remember that a normal menstrual period should not be accompanied by these symptoms. We must especially remember that a very slight flow between the menstrual periods is of very grave significance and it behooves all of us to do what we can to educate the women who may come under our supervision, and the public in general, as to the necessity of thorough pelvic examinations, and when defects are found, to have them removed early. For even if the condition is not one of cancer, we can by either medical, surgical or radiation, or a combination of the three, make life worth while for these patients. And should the condition of some of these women prove to be malignant, early and frequent examinations enable us to detect the trouble while it is curable.

(Continued from Page Six)

gested. He describes the normal gland, and tells how it functions. He discusses the relation of diet and almost all human activities to the thyroid, play, study, stress and strain. This book is dedicated to the great and learned Chas. E. Sajous. It is so interestingly written that you will almost forget and think you are reading a novel. You can practice by it and fear no evils. The price of this priceless book is only four dollars.

Allergic Diseases, Their Diagnosis and Treatment, by Ray M. Balyeat, and published by F.

A. Davis Company, is so new that it smells of the ink. It is the third edition revised and enlarged. This is a subject that worries every man in the practice of general medicine and almost every one who practices medicine or surgery at all. Dr. Balyeat takes up the causes of asthma, hay fever, and allied conditions. He traces very clearly the causes as they are related to plants, animals and fowls et cetera. He discusses the intradermal tests for susceptibility of same. He discusses treatment, both curative and palative, and diet in a manner that can be understood and followed. This is a book that will prove a friend in time of need. F. A. Davis Company, Philadelphia. The price, five dollars.

THE DOCTOR'S WIFE

By MRS. T. B. HOLLOMAN
Itta Bena, Miss.

The woman who is honored most in song and story is "Mother." Next to mother, I beg the privilege to place in rank of honor, the Doctor's Wife, the silent partner of the medical profession. Silent, though always on the job, because you of the medical profession, more than any one else know and understand that mistic hour of joy and pain that puts the hallow around mother. You will know and understand why I place the doctor's wife so highly whether she be a mother or not.

This partner of yours has kept pace with you along every line save one—she has not been permitted to specialize. You can choose the line of work you like best and for what you are most fitted and attain perfection in that line. Not so—your partner—she must be perfect in many lines. First, as a home-maker she must practice the laws of hygiene to demonstrate your teachings. For the same reason the children in the home must be kept physically fit. She must be prepared to give first aid to the neighborhood children as well as her own when the "doctor is out," keeping a supply of bandage, iodine, etc., for stumped toes, cut heads and the like. The doctor's wife, more than the wife of the minister, is called upon to bring joy and sunshine into the sick room; to drop the sympathizing tear and words of comfort or as the intercessor asking divine blessings on the means being used to restore life and health. In the religious activities and social affairs of the community she is expected to be in the forefront. She must not only be a friend to the elite of the community but the poor and humble, including the colored races.

Sometimes this partner of yours must have business ability. Helping with the book-keeping when a rush of calls comes around the first of the month.

Last but not least, she must rival the telephone girl with a pleasant voice and courtesy (and all this, maybe, after a sleepless night) and her reward—to go alone to seek recreation at the theatre party while you are "making a call."

May I remind you of the mythological story of Theses and his love. How, when he was leaving to go to the forest to conquer the wild beast, his love tied a silken cord around his arm, retaining the ball of cord. She told him when he was in danger the cord would tighten around his arm reminding him that she was thinking of him and praying for him. When you are away from home battling with disease the silken cord that tightens around you is a prayer in the heart of this silent partner—with all honor to that one, second only to "Mother" "The Doctor's Wife."

A WORD TO ASSOCIATION MEMBERS

By E. F. HOWARD, President
State Medical Association, Vicksburg, Miss.

In the September issue of the New Orleans Medical and Surgical Journal will be found, on page 189, an article on membership that gives a birdseye view of conditions in the state. Let us fit this to the Northeast Mississippi Thirteen County Society.

In the first place, since that article was written there has been a change in the membership which produces a corresponding change in the percentage. This should be 74, instead of 71 as given; somewhat of an error even though it does not change the society's position in the column. This percentage is quite high for so large a society, but isn't quite as good as it should be. Why not let all the rest of the counties get busy and get in the class with Clay the 100% county?

The tabulation given below shows the membership in the various counties in 1913 and 1930 and the number of non-members at present. 1913 was chosen for comparison because it marks the peak of the Association's initial growth. That was the year the Association stopped growing. The figures in the third column were taken from a list checked by your very prompt and efficient Secretary, Dr. Acker.

	1913	1930	
	Members	Members	Non-Members
Alcorn	13	12	3
Calhoun	11	10	6
Chickasaw	7	11	2
Clay	16	11	0
Itawamba	2	3	7
Lee	19	28	10
Lowndes	9	15	11
Monroe	16	21	7
Noxubee	----	10	4
Oktibbeha	13	9	5
Pontotoc	13	10	4
Prentiss	13	9	2
Tishomingo	----	7	4
Non-Resident	4	5	----
	136	161	65

This tabulation shows that some of the counties have lost membership since they became parts of the large group. In 1913, operating as single-county societies, or members of small groups, several made a better showing than they do today. This is one of the weak points of a large group. It is difficult to keep in touch with individual members over so large a territory, and since Noxubee and Tishomingo were temporarily laid up for repairs in 1913, the total gain is more apparent than real. Still, it is comparatively good.

You men up in North Mississippi have done so well, considering the size of your territory, that I have nothing but praise for you. But won't you do me a favor? Turn those sixty-five non-members into members as a New Year's present to the Association.

Good luck to you.

DEGREES

The world is made of folks like these—
The learned ones who hold degrees;
The ones who don't know what they mean,
And all the masses in between.

Degrees are numerously held,
And of assorted letters spelled.
There's everything from just A. B.
To the astounding Ph.D.

The folks who've earned these fine rewards,
Have known the aids this age affords,
And learned the hows and whens and whys
That college courses all comprise.

Way down along the knowledge scale
Are those on such a lagging trail,
That little things like special mention
Have never come to their attention.

And in between these two extremes
Are folks by millions, flocks and reams,
Who want B. S's and A. B's
And all such merit marks as these,

And yet, for reasons very good,
Have never found just how they could,
In view of obstacles that rise,
Accomplish aims of merit size.

And that's the way it seems to go,
Folks line up just in one long row,
And most of them, it truly seems,
Are in between the two extremes.

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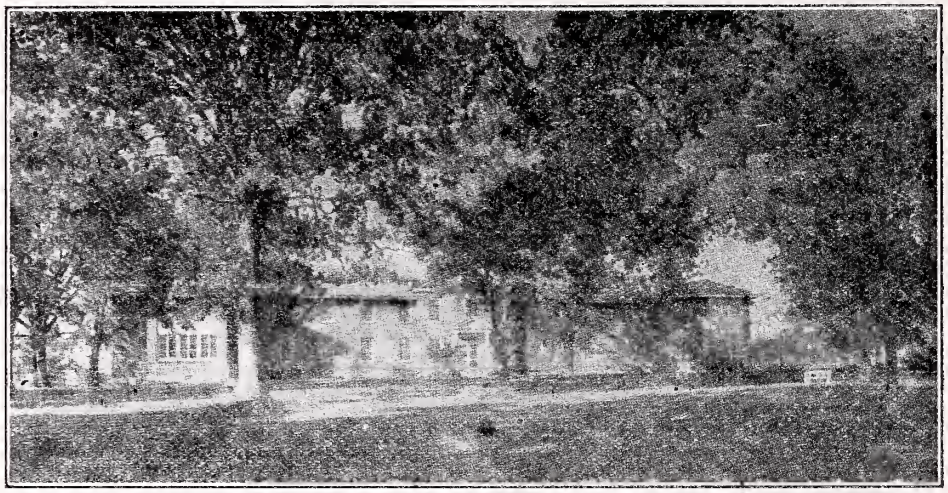

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VOLUME 8 BOONEVILLE, MISS., OCTOBER, 1930 NUMBER 4

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MERCY

"The quality of mercy is not strain'd,
It droppeth as the gentle rain from heaven
Upon the place beneath: it is twice blest:
It blesseth him that gives and him that takes:
'Tis mightiest in the mightiest: it becomes
The throned monarch better than his crown;
His sceptre shows the force of temporal power,
The attribute to awe and majesty,
Wherein doth sit the dread and fear of kings;
But mercy is above this sceptred sway;
It is enthroned in the hearts of kings,
It is an attribute to God himself;
And earthly power doth then show likest God's
When mercy seasons justice."

—Shakespeare.

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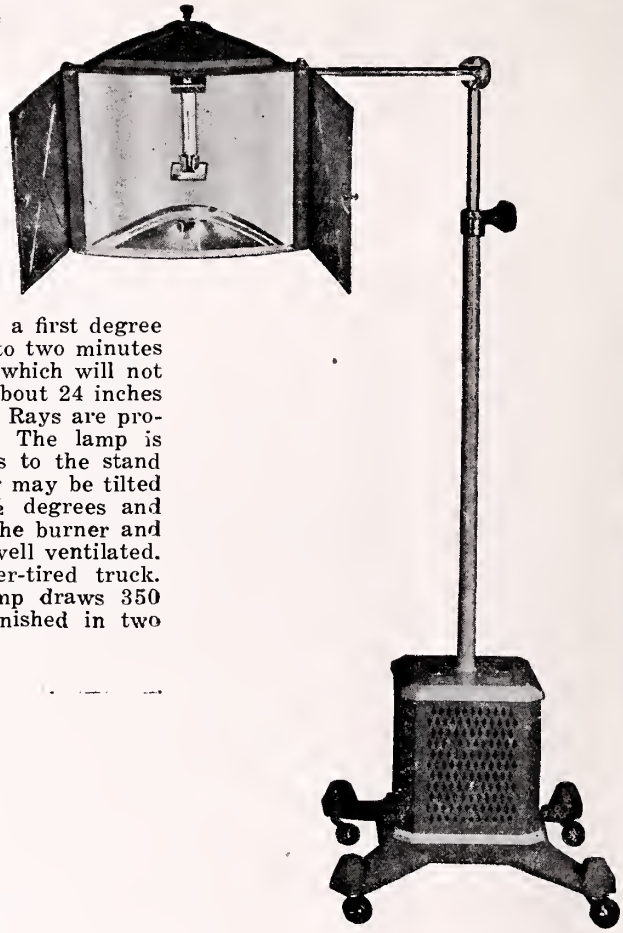

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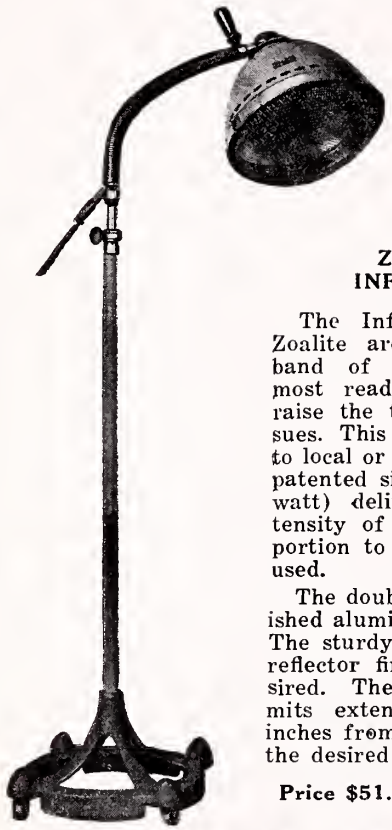

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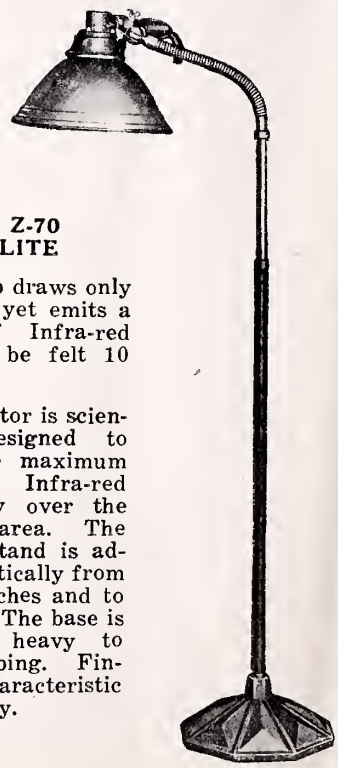

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Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

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Our next meeting is to be held in Aberdeen. That city will treat you in a most royal manner. The scientific program will be good. Be wise and be there. You can't buck the hard times successfully by closing up in your shell.

To be well equipped there should be one hospital bed to every one hundred and fifty people. Mississippi has one bed to every 1,054, says the statistician. In the United States we have one practicing physician to every 800 population. Mississippi has one active man to about twice that number. New York State has one hospital bed to 175 population. Again we are impressed with the importance of a proper distribution of physicians and hospitals. The small community hospital is the only solution, as to distribution and as to a reasonable price.

We appreciate very graciously the list of new subscribers coming in recently from the sample copies sent out. We hope you may be pleased with the journal. We shall be glad to have a paper from your pen. If you have a medical thought send it along. If you have an interesting case write it in brief and we shall be delighted to pass it on through our columns. You are now one of us.

Drs. Underwood and Applewhite are having calls to other states with all expenses paid to tell them how the public health job is done in Mississippi. This is quite a credit to our health department and a compliment to the splendid work of these men.

You will read with pleasure and profit the paper by Dr. Oscar W. Bethea, on the Treatment of Pneumonia. Mississippi feels an especial pride in the success of Dr. Bethea as he was, for many years of his earlier life, one of the leaders in pharmaceutical affairs in the state. He is peculiarly suited now to speak with some authority on medical diseases, as he is a member of the senior faculties of both the undergraduate and post-graduate schools of the Tulane Medical College, and is also Chief of Medicine at the Southern Baptist Hospital and Senior Visiting Physician at the great Charity Hospital at New Orleans. Pneumonia has continued to claim its heavy toll in spite of the many and varied plans of treatment. Most of these are complicated, expensive, time-consuming and certainly unavailing, so it is refreshing to read of one so simple that any practitioner can carry it out in the home and yet one so effective as to furnish such statistics as Dr. Bethea presented at the Detroit meeting of the A. M. A. It may be said that the plan of treatment offered is profound in its very simplicity, and you can depend upon Dr. Bethea's books and papers and you may practice by them in safety.

We want to thank Dr. Lippincott for sending

(Continued on page 14)

A TREATMENT OF PNEUMONIA

OSCAR W. BETHEA, M.D.,
New Orleans

Drugs, biologicals and special therapeutic measures by the score have at one time or another been advocated as specific for the treatment of the pneumonias, yet this group of diseases continues to exact its toll of life and the percentage of mortality has even increased in the last few decades. Progress has been made in the management of typhoid, tuberculosis, syphilis, malaria, and in fact most all ills to which human flesh is heir. Why have we failed with pneumonia? Medicine has advanced in every department, dietetics are on a scientific basis, drinking water is purer, ventilation and heating are better, the facilities for early diagnosis have multiplied, and such factors as these alone should have improved our results unless there was error somewhere. Is it not possible that we are overtreating these cases? So many fascinating activities have been suggested—serums, vaccines, glucose infusions, ice-packs, oxygen, routine digitalization, quinine, strychnine, atropine, morphine, adrenalin, ephedrine, barbituric acid compounds, active purgation, high caloric diet, and unmodified cold air—that one feels remiss unless some of these are tried. In tuberculosis, typhoid, and many other conditions, we made headway only when we began to treat the disease less, and to treat the patient more—that is, to give more attention to the details of general care.

Specific serum offers much of promise, but only a very small percent of these patients have available the facilities for determining type or applying treatment, and only a small percent of these prove to be favorable for such therapy.

The statistics of the Rockefeller Institution, on Type I cases are exceedingly good, but other hospitals have not been able to attain to such results and much of the success in these cases may have been due to the unparalleled facilities that were employed in the intensive attention to the geeral care of these patients.

The plan of treatment presented before the Medical Section of the American Medical Association at Detroit was the outgrowth of experience beginning with the first pandemic of influenza (1918). Confronted with the care of a large group of pneumonias of a variety entirely new to me, I treated the patients (not the disease) for want of anything better to do. The results were so encouraging that some of my confreres joined me in applying the plan to the management of practically all of our pneumonia cases, and with slight modifications, dictated by experience, we have continued to use it. In presenting statistics I only included the last 50 cases treated in hospitals during approximately the last two years. The mortality was 10 per cent. These were primary pneumonias and did not include any of those who were first seen when in extremis or those receivin specific serum. It is freely admitted that clinical statistics are of questionable value and this particularly applies to the consideration of a small group. This plan, however, has been employed in the treatment of quite several hundred cases and we have not yet had occasion to consider a change or to regret our policy.

It is not the intention to urge the adherence to any definite routine, but only to outline a general plan. Individualization is always necessary in the practice of medicine.

When a positive or even a tentative diagnosis is made, a multigraphed form is attached to the records of the patient for the guidance of those concerned. Digressions, if any, are entered in writing. This form reads: "WARD SUGGESTIONS FOR ATTENTION OF PNEUMONIA PATIENTS." (This appeared in full in the Journal of the A. M. A., Sept. 27th, 1930. The essential features are as follows:

1. Infinite attention to all the details of general care. The patient is seen at least three times in each twenty-four hours. Absolute mental and physical rest are employed, that the circulatory apparatus may be conserved. As far as is possible the patient is made to lie on his back or on the affected side.

2. The plan of modified fresh air is followed. That is, in cold weather the patient is placed in a room that has an open fireplace if that is possible. In the hospital the room is comfortably heated, but all possible fresh air is admitted without exposing the patient to uncomfortable drafts. Under no circumstances are oil or gas heaters allowed in the treatment quarters.

3. Careful attention is given to oral hygiene, and bodily cleanliness.

4. Active purgation is avoided, but sufficient intestinal elimination is maintained Liquid petrolatum is given as a routine. Castor oil is given if necessary. necessary.

5. Mild alkalinization is employed, preferably in the form of sodium citrate. Some of my associates use combinations of alkalies.

6. When stimulation is needed, aromatic spirits of ammonia is used freely, and throughout the progress of the case, the tea or coffee to which the patient is accustomed is given.

7. Digitalis is only used under conditions that would call for this drug if the patient did not have pneumonia, (auricular fibrillation, auricular flutter, etc.). Morphine is not employed excent in the case of some gross complication, as peridcarditis.

8. The only sedative used is codeine in the smallest doses that will meet the requirements.
In the overwhelming majority of cases, no other medication than that stated above is given.

9. Mustard poultices are tried if there is a sense of depression or constriction in the chest; they are not continued unless they afford a sense of relief.

10. A low total, high carbohydrate diet is used. No effort is made to give large amounts of food. The disease is a short stormy process and 1,000 to 1,500 calories per day will bridge over the time between diagnosis and crisis.

The patient is kept in bed for at least two weeks after the temperature reaches a permanent normal.

ORGANIZED MEDICINE

M. J. L. HOYE, M.D.,
Meridian, Miss.

Mr. President and Members:

I am talking to you at the request of Dr. Howard, President of the Mississippi State Medical ssociation, on one phase of Organized Medicine.

I have been called upon to re-enact the miracle of raising the dead, or perhaps more strictly speaking, to transplant some "monkey glands" into this prematurely aged group of medical societies, which seems to be languishing on a bed of carelessness and indifference. I must confess, to start with, that in attempting to accomplish that task, I am as much "up a tree" as the proverbial monkey, but I have an intuitive feeling that through some manner of strategy, I may be able to descend without too sudden a jolt, for I know that whatever I say, will be said with the utmost sympathy for those who are facing the perplexing problems of maintaining and increasing society membership, and with the sole purpose, not of criticizing, but of offering you a plan, which may prove of value in creating new life in your local society, thereby enlarging your contact with our state society. With that motive uppermost in my mind, the task of talking to you loses any trace of bitterness and becomes a pleasure and an honor.

I have here some statistics, which have been prepared by Dr. Howard, at Vicksburg, and which I am passing on to you:

Counties—	Per Cent Members
Clay County has a membership of	100%
Chickasaw " " " "	84%
Prentiss " " " "	81%
Alcorn " " " "	80%
Monroe " " " "	77%
Lee " " " "	73%
Noxubee " " " "	71%
Oktibbeha " " " "	69%
Pontotoc " " " "	66%
Calhoun " " " "	62%
Tishomingo " " " "	60%
Lowndes " " " "	53%
Itawamba " " " "	30%

It will be seen from these figures that the per centage of eligibles who are actually members of the state and local societies runs from 100 per cent, as is the case of Clay County, to 30 per cent in Itawamba County, with the average running around 75 per cent. You will notice that only one county has 100 per cent, and the next closest, Chickasaw County, has only 84 per cent. There are none in the ninety per cent group. Obviously there is room for improvement in practically every county.

In undertaking to deal with this problem, we assume, of course, that the county or state medical societies have merit of proven value, otherwise our time and work would be totally wasted, and of no value. Lest there are some, however, and I'm sure there are, who are not fully conscious of the obvious benefits to be derived from being a member of the state society, let me mention one or two of the more important ones.

In this day and age, a certain type of people are always on the lookout for flaws in the doctor's practice, whereby they may bring suit for malpractice. If you are a member of the State Medical Society, you need never worry about the details of hiring a lawyer, providing witnesses and the necessary expert testimony called for in the case. The association takes care of it entirely for you, and at the same time assures the moral backing of the entire association.—no small item in persuading the judgment of the court. A case in Meridian comes to my mind as a fine example to emphasize my point. One of the best known surgeons in Meridian has been confined to his bed for the past twenty-four weeks. Prior to his illness, a suit was filed against him. The illness came at a most inopportune time and would have presented serious problems, had he not been a member of his society, which has taken over the case in all its details and the surgeon in his helpless condition is not subjected to the stress and strain of the worry which might have hastened his death materially.

Another value which the society offers is group insurance. Every member is allowed insurance up to $6,000 without medical examination. The insurance company pays its claims promptly. During the past two years it has actually paid more in claims than the premiums that the men have paid in.

And then the society helps in editing and publishing the New Orleans Medical Journal, and every member of the state society receives this journal monthly on the first of the month. This journal measures up in every way to the highest standard of scientific editing, and it alone, is worth more than the price of annual dues.

Aside from all tangible advantages that invincible force of friendship and fellowship means more than can be expressed in any way, except through actual experience. Surely each one of these reasons, is in itself sufficient to persuade the thinking man to join the state and county societies.

Dr. Howard, the president of the state society, has outlined the following plan, and it strikes me as being an ideal one that can be followed very easily by your society. He has asked me, as one of the vice-presidents of the state society, to present the plan to you, and in view of the amazing possibilities that lie in the plan, I am more than pleased to spend my time here with you on this mission.

Heretofore the office of the vice-president of the Mississippi State Medical Society has carried a lot of honor without attaching any definite responsibility. Dr. Howard is determined to get some work out of them and if his plan succeeds they will hold the most responsible office in the association and such officer will be held in high esteem by his fellow members. The

work he has allotted to them is to bring within the fold about 450 members of the profession in the state who are not now members of their local county medical societies, although they are in every way eligible. He has given me, as vice-president representing the Third, Fourth and Sixth districts, the honor of presenting his plan to you. His plan is for us to meet with as many societies in our allotted districts as possible and bring this matter to your attention. He, too, realizes that the secretaries of these societies are already over-burdened with duties and suggests that the local county vice-president also be given a definite responsibility,—that responsibility to be the collection of due for his county and the bringing into the association the doctors of his county who are eligible, but for some cause have not joined. As an incentive for persistent endeavor and a reward for hard earned achievement, he suggests that the vice president who makes the best showing, be elected president of the society at the next annual election in December. The plan will avoid laying any extra responsibility on the already mentioned overburdened secretary. The need for this shift of responsibility is evident where the following facts are known. In group societies, the county in which the secretary lives shows the highest percentages in all counties. The four societies showing the highest percentage of members, are societies composed of single counties. These facts serve to indicate that the counties in direct contact with the working centers of the society, the secretary shows a distinct benefit from this close affiliation. It is for that reason that I want to stress the value of the plan I have described in which the vice-president of each county society shall be made an effective worker within that county. The burden on each vice-president will not be taxing and you can readily see that to impose this added responsibility on the overworked secretary would be futile and ineffective. The plan has already been adopted by the East Mississippi Four Society and is working splendidly, and I understand from Dr. Robinson that some of your county societies have already delegated your vice-presidents to act in the capacity of "membership secretary." If this has been done, then no further reorganization is required, and I need only to urge you to renewed activity, executed in a more determined spirit than has ever motivated your efforts in any previous task.

It must be impressed upon you, that the only way to way to increase your membership is through your own local societies, and this duty in the past has been placed upon your secretary. We cannot go beyond your local officers.

We have a complete list of names of men who are eligible for membership in your society and I will gladly furnish them to you. You understand, of course, that membership in your county society automatically makes you a member of the state society.

I repeat, the only way to increase the membership in your local society, is to get next to all these men who are eligible for membership, and not only invite them to join, but make it imperative, and keep after them until they are members. I therefore suggest that you commission your vice-presidents as captains of this drive, and I shall look forward expectantly to a number of 100 per cent societies.

I commend you on having Dr. J. M. Acker as secretary. His good work and his assistance from each county vice-president has given you a membership which is high in the association.

This society should be proud of your publication, "The Mississippi Doctor." I assure you that it is read regularly with the same interest and enthusiasm that the more widely distributed journals enjoy. It is a valuable medium of expression and deserves the whole-hearted support of the profession at large.

I could not close without mentioning our reverence for one of our past presidents, now a member of this society, Dr. G. S. Bryan. He is loved by us all and it is our sincere wish that his life of exemplary usefulness will be prolonged into many more years of happy service to his community.

I thank you.

HYPERTENSION*

S. W. JOHNSTON, M.D.,
Vicksburg, Miss.

I know of no good definition of hypertension. I know of no real explanation for the condition. Wriss and Ellis offer this explanation which I believe covers the ground as well as any other. Because of an abnormal accentuated arterial resistance, a high arterial and arteriolar pressure is essential to establish a normal capillary blood flow and a normal pressure in the vital organs. The etiology is extremely obscure. Several years ago the concensus of opinion was that it was due to focal infections but all observers have found out that removal of all possible focal infections does not even temporarily reduce the pressure. Galata attributes hypertension, especially that of the climacteric, to hyperfunctioning of the suprarenals. He bases his contention on the results obtained on a woman of 56 whose blood pressure fell 55 mm. the first day after a unilateral suprarenalectomy and during the following three days fell 40 mm. more. I doubt that observations of a single individual should merit much support. For a while many observers thought the peripheral blood vessels were at fault, but Strisower has conclusively demonstrated that injury to these vessels cannot cause a raising of the pressure. He thinks, and he has a great many others agreeing with him, that the condition is one of a central disturbance and that the fault lies in the vasomotor nerves.

Age plays a very important part. Palmer found in a group of Harvard students that ten

*Read before the Issaquena-Sharkey-Warren Counties Medical Society, Vicksburg, August 12, 1930.

per cent had hypertension. Of 66 controls ten years later only three had systolic blood pressures of 140 and only one had above 150. Of 49 who had had hypertension ten years earlier, six had blood pressures of over 140, five had over 150 and one above 180. This shows conclusively that once a hypertensive patient always a hypertensive patient. I think Palmer's findings were very high for hypertension among boys under 20. It has been my experience that high blood pressure in young men is extremely rare.

I think that the exhaustive study made by Blackford, Bowers and Baker throws more light on the results of hypertension than that of any other observers. They carefully checked the physical examination of ten thousand persons who had applied for health examinations. Of this group 401 showed systolic blood pressures of 175. Less than one per cent were under the age of 30. Only 1.2 per cent were between 30 and 40; 5.8 per cent between 40 and 50; 12.3 per cent between 50 and 60; 22.5 per cent between 60 and 70; and, very strange there was a drop to 14 per cent between 70 and 80. Only 10 per cent after 90 had blood pressures of 175 mm. The women outnumbered the men two to one. Half the cases did not complain of cardiac symptoms. Dizziness, vertigo and headache occurred only in one-third of the cases. By x-ray 168 showed broadening of the aortic shadow. Only 18 had positive Wassermann reactions, 21 had diabetes, 58 gall bladder disease, 25 toxic goitre, 27 valvular heart disease. There were only six of this group who had acute or subacute nephritis. It seems that the gall bladder played a very large part in the incidence and syphilis a very small part. They were able to follow up 222 cases. Twenty died shortly after the examination. Of the remaining 202, exactly 101 are dead.

The average life of this group was 35 months. Of 73 males, 57 died within an average of 32 months, giving a mortality of 70 per cent. The 129 females gave a mortality of 39 per cent and the life average was 44 months.

The diastolic blood pressure was indeed interesting. Up to 110 the mortality was 39 per cent; from 111 to 120 it was 59 per cent; from 121 to 130, 65 per cent; above 130 it was 94 per cent. Seventy-one of the 101 women are still living. One woman with systolic blood pressure above 300 and whose blood pressure can be traced as far back as 1909 when it was said to be above 300, is in good health. From this we can absolutely and undoubtedly conclude that hypertension in the woman is not as serious a condition as in the man.

Among the conclusions drawn by the gentlemen were these: Family plays a large part. One-third of all cases give histories showing that other members of the family had hypertension. Syphilis plays a rather unimportant part. Gall bladder trouble plays a large part. Toxic goitre also takes a heavy toll. Not one single case that was followed up was ever relieved of hypertension.

Women may outlive their expectancy, men never do. They make no note of essential hypertension in the young adult but, girl or boy, the mortality is appalling when the systolic pressure exceeds 160. I know of no condition that offers so little hope as that of hypertension in the young. As to the treatment. There can be no doubt that first of all the patient must not worry. Whether worry and anxiety cause hypertension or not, both will keep it up.

I think in my rather limited experience financial troubles and loss of sleep from financial worries cause hypertension to continue more than any other conditions. Heavy physical and mental work certainly play their part in the disturbance. Heavy eating and heavy drinking also work to the disadvantage of the hypertensive patient.

Recently two hypertensive patients of mine died suddenly of angina pectoris or coronary thrombosis and I am sure both deaths were brought on by over-eating. In the hypertensive patient with a history of either of these conditions you can rest assured that an attack and usually a fatal one will follow over-eating. Quietude, restfulness, and moderation in all things are the surest remedies. Drugs by the score have been used. In my hands I think I get best results from large doses of potassium thiocyanate given three times daily. I have lost faith in sodium nitrate and nitroglycerine. Citrin has not given me much in results. Of course if we find any pathological condition, that must absolutely be treated. All focal infections must be removed. Syphilis must be cured; constipation relieved; the gall bladder and thyroid looked after. But in the real hypertensive patient it is hard to find a cause.

SEASONAL HAY FEVER*

EDLEY H. JONES, M.D.,
Vicksburg, Miss.

There are two types of hay fever or pollenosis, as it is more correctly named; the seasonal type which affects a patient at a certain season, or seasons, of the year; and the perennial type which affects patients constantly or intermittently throughout the year. Only the seasonal type will be discussed in this paper.

HISTORICAL

As early as 1673 hay fever was mentioned by Berninderus. In 1819 John Bostock of England described his own case of "A Periodic Affection of the Eyes and Chest," and in 1828 published another paper describing a series of twenty-eight cases. Some of his patients called the condition "hay fever" and the name has stuck, the patients very rarely have temperature. The principles underlying the diagnosis and treatment of hay fever were first applied by two Englishmen, Noon and Freeman. These principles were elaborated and developed by Koessler, Coca, Cooke and others.

*Read before the Issaquena-Sharkey-Warren Counties Medical Society, Vicksburg, August 12, 1930.

ETIOLOGY

It has been definitely proven that hay fever is due to a peculiar individual sensitivity to pollen, or pollens, of plants. Botanically speaking, plants are divided into the wind-borne and the insect-borne pollinated plants. Practically all cases of seasonal hay fever are due to wind-borne pollens. These pollens are very light and a brisk wind will carry them easily five to fifteen miles.

Insect-borne pollens are heavy and sticky and for that reason are not widely distributed in the air. Wind-borne pollens come from trees, grasses and weeds; insect pollens from flowers, where bright colored and sweet odors attract insects. A few cases of seasonal hay fever are unquestionably caused by insect-borne pollens, but these are the exception rather than the rule.

The plants that most frequently cause hay fever in this locality are: Elm, cottonwood, oak, box elder, sycamore, ash, hickory, pecan, black walnut, river birch, swamp cypress and mountain cedar trees; blue grass, orchard grass, Johnson grass, bermuda grass, red top grass and timothy hay; marsh elder, careless weed, red root pigweed, lamb's quarter, annual sage, giant and short ragweed. Dr. J. P. Henry of Memphis has compiled and published a botanical survey of all plants in this region and their dates of pollination.

SYMPTOMS AND SIGNS

The classical symptoms of hay fever are: Blocked nasal passages with a constant, free, seromucuous discharge; frequent spasmodic attacks of sneezing; eyes red, watery and itchy; itching of nose and naso-pharynx. These symptoms appear at approximately the same date each year; it has been shown that the dates of pollination vary little from year to year. Due to the nose blocking and general discomfort, sleep is frequently broken and seasonal hay fever patients are usually restless and irritable during attacks.

The nasal membrane has a typical appearance. It is pale and very edematous, with profuse muco-serous discharge. Shrinking the membranes gives only temporary relief. The conjunctiva is usually injected and the eyes are watery.

Not all patients present this typical picture but the history of their symptoms recurring at the same season, year after year, is diagnostic.

DIAGNOSIS

If the patient has suffered more than one season, a carefully taken history is all-important. A diagnosis can be made from such a history alone; in fact, many times one may surmise the offending pollen. However, if the patient presents himself for examination during the first season, a history is of little value. This was proven the other day by a case that presented herself at my office. On testing, the young lady was found not to be sensitive to any pollens, but quite sensitive to feather dust, and other animal epithelials.

The diagnosis is made by testing the patient with pollen extracts. There are two methods in common use: "scratch" or cutaneous testing, and intradermal testing. The "scratch" method consists of "scratching" the skin with a dull knife, incising the epidermis but being careful not to cut deep enough to draw blood. A drop of the pollen extract is applied and massaged into the skin with the rounded end of a sterile tooth pick. The intradermal test consists of injecting .05 cc. of the extract between the layers of the skin. The scratch test is not as delicate as the intradermal, but should always be given first, for safety. Some patients are so sensitive to certain pollens that injections in the skin may result in a violent systemic reaction; such a reaction never results from a scratch test. Should the patient have a negative or doubtful reaction to a pollen extract, he should then be tested intradermally. A positive reaction causes a wheal. surrounded by redness; large reactions have pseudopods.

Seasonal hay fever patients should also be tested for sensitivity to animal epithelials and other substances that are commonly encountered, such as feathers, hair and dander of animals, (domestic and fur bearing), orris root (used in face powders, soaps, etc.), pyrethrum (used in insecticides), cotton, flaxseed, binding twine, etc. Sometimes a seasonal hay fever patient will be sensitive to such substances and will not get complete relief until contact with them is eliminated.

TREATMENT

The proper treatment is to desensitize the patient with an extract of the pollen, or pollens, to which he has been found sensitive. Best results are obtained by pre-seasonal treatment, starting with .05 cc. of a 1:2500 solution and working up to a maximum of .50 cc. of a 1:50 solution just at the beginning of the season; then continuing this maximum dose at intervals through the season. Unfortunately most patients do not present themselves for examination till suffering and can only be given co-seasonal treatment that year. Co-seasonal treatment usually benefits them a great deal, but never gives the relief obtained by combined pre-seasonal and co-seasonal treatment.

OTHER FORMS OF TREATMENT

A few years ago several rhinologists felt that hay fever was in a large measure due to an infected sinus and advised operation on all diseased sinuses associated with hay fever, on the theory that the diseased sinus was the etiologic factor. Quite a large percentage of cures were claimed. The consensus of conservative opinion at present is that no seasonal hay fever case should be operated during an attack; after the attack the patient should be re-examined and any obstruction or sinus pathology then remaining should be corrected. It has been noted that ethmoid and maxillary sinuses frequently appear definitely diseased during a hay fever attack, only to appear normal after the attack is over. However, Hurd recently advised radical operation on the ethmoids in cases of hay

fever the Allergist has failed to diagnose, though he emphasizes that they should be first tested for pollens.

In 1923 Novak and Hollender advised thyroid extract and calcium lactate for all affected cases. They noted better results when ultraviolet ray therapy was given at the same time. It appears reasonable that the principal value of such tonic treatment is that it builds up the patient's resistance.

Some years ago Sluder injected the sphenopalatine ganglion in a case of hay fever. Lately, this method has been revived and Ruskin recently published a paper calling attention to it. Byrd recently published a paper entitled "Hay Fever; Its Surgical Conquest," advising the alcoholic injection of the spheno-palatine ganglion and the naso-cillary nerve as it passes from the orbit through the anterior ethmoidal foramen. When we consider that hay fever is a vaso-motor disturbance, we can readily understand that the injection with alcohol of the sensory nerves might afford some relief; but it also appears logical that, in destroying the sensory ennervation of the entire nasal membrane, we would be doing the patient an irreparable damage.

It would appear best that when we have a case of hay fever due to a heavy pollen that the patient eliminate all contact with this plant; and in cases due to wind-borne pollens that the patient be desensitized. While this method is not one hundred per cent successful, it offers the largest amount of relief and has fewer drawbacks than any other method that has been described.

SOME CAUSES OF FAILURE

Lack of knowledge concerning present day methods is widespread. Allergy is such a new specialty that it is still not included in the curricula of most medical schools and, unless one makes a special effort, it is difficult to keep up with advances in this field.

Lack of knowledge concerning the botanical flora, dates of pollination, etc., may account for some of the failures. A patient may be tested with only a few pollen extracts when he should be tested with every toxic pollen in his locality.

Perhaps the largest number of failures are due to faulty methods of testing. When the scratch test alone is used, it is not sufficiently delicate to accurately diagnose all cases. To obtain best results it is necessary that the intradermal test be used though, as mentioned above, the scratch test should always be used first, for safety's sake. Again, group testing is sometimes employed. Pollens of plants of the same botanical group are grouped together in one extract, and only one test made for the entire group. If a patient is tested with a pollen to which he is susceptible, grouped with foul pollens to which he is not susceptible, it is logical to assume that the reaction will only be one-fifth as large: in cases of moderate susceptibility, the reaction may be so mild that it is not noticed.

It might be emphasized that failure to test seasonal hay fever patients with miscellaneous substances, such as animal epithelials, etc., as described above, will result in some cases not being entirely relieved.

Inasmuch as some cases are caused by the heavy pollens, patients that are not diagnosed and relieved by the ordinary methods, must also be tested with extracts of these pollens.

Some failures are due to "shot gun" therapy, or improper sets of "trees," "grasses," "ragweeds," etc. It is well known that non-specific therapy cannot give the results achieved by specific therapy. If a patient is treated with a "shot gun" serum, containing pollen extracts to which he is not sensitive, such extracts take up space in the treatment, but fail to call forth any antibodies. As a result, the patient does not get sufficient dosage of the offending pollen to confer immunity.

Again, inadequate dosage may be a cause of failure. The so-called "fifteen dose treatment" can hardly be expected to give results. It is necessary to start with a dose that is too small to give a reaction; it must be gradually increased till the patient is taking a maximum dose, which should be continued at intervals throughout the season.

CONCLUSIONS

1. Seasonal hay fever is an allergic disease, due to a peculiar individual sensitivity to the pollen of a certain plant, or plants.
2. When proper methods of testing are used, the offending pollen, or pollens, can be identified in practically all cases.
3. Treatment by desensitization apparently gives the best results.
4. "Shot gun" treatment and inadequate dosage are to be condemned.

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ENRICHING HUMAN LIFE THROUGH FORM AND COLOR

MRS. JOHN B. SANDERS
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"God made the country; man made the town," says William Cowper, and almost every one will agree that it is the deprivation of the colour of the country that makes the towns so sadly depressing, for nearly all people appreciate colour, though perhaps in a general way. They realize that colour helps to beautify the world.

Other people, however, look upon colour as one of the greatest joys in life. The colour of

the woods, the flowers, the sunrise, and the sunset are sources of the very deepest emotion, exalting them above mere interest in external things into the very highest realms of vision and beauty. The colours of an artist like Titian make them realize the joy of living. Even the word-pictures of the poets do the same, so that they become firm believers in the poetic fallacy that what is beautiful in nature reflects what is beautiful in the mind of man. Thus Buddha watching the sun rise seems to clothes Nature with his own luminous soul, which is striving to make a new age begin on the earth.

Edwin Arnold, in his "Light of Asia," tells us that the Buddha rose just before the False Dawn and stood—

"Watching the sleeping earth with ardent eyes
And thoughts embracing all its living things;
While o'er the waving fields that murmur moves
Which is the kiss of Morn waking the lands,
And in the East that miracle of Day
Gathered and grew. At first a dusk so dim
Night seems still unaware of whispered dawn,
But soon—before the jungle cock crows twice—
A white verge clear, a widening, brightening white,
High as the herald star, which fades in floods
Of silver, warming into pale gold, caught
By topmost clouds, and flaming on their rims
To fervent golden glow, flashed from the brink
With saffron, scarlet, crimson, amethyst;
Whereat the sky turns splendid to the blue,
And, robed in raiment of glad light, the King
Of Life and Glory cometh."

As we read the passage the whole scene arises before us, of the lonely watcher and the glorious Eastern sky. In other versions of the same event, we have more definite teaching concerning these beautiful sunrise hues. The Buddha plays his vina and the colour of the sky changes according to his seven notes—yellow, blue, violet, green, pink, white, and cream; not colors given by chance, but of deep esoteric meaning.

There has always existed a belief in the essential connection between colour and sound. That is why in every day language we say "a colour clashes" or "a color harmonizes"—both terms from the sister art of music. The scientist has now worked out this connection, so that we have the following facts:

A tenor voice produces 400 vibrations per second.

Red light, 400,000,000,000,000 vibrations per second.

A soprano voice, 700 vibrations per second.

Violet light, 700,000,000,000,000 vibrations per second.

Thus light gives a finer vibration than sound to the extent of a million million times, and this is one reason why, when the mind is so tired that even music seems wearisome, it can be healed by means of colour.

Few people recognize that colours are powers, forces, vitalities, and vibrations. Yet such they are, and on the physical plane we are now learning to enlist them in all kinds of occupations, as varied as that of the physician, the gardener, and the baker. Every year we are finding out more clearly how we can use these vibrations for the benefit of man. Every year new hospitals are being opened for colour. In the East Moline State Hospital of Illinois, for example, colour is employed as a definite therapeutic agent. A patient suffering from functional excitement is placed in a room decorated entirely in blue—walls, draperies, floors, furnishings, lighting fixtures. Here a soothing, quieting effect is produced that exerts a modifying influence on the patient's mood. In a red room, patients suffering from functional depression are stimulated, with opposite effect.

Chromotherapy, or the use of colour for its emotional value, is commanding more and more attention. In schools, hospitals, offices, industries, and in homes, colour is being studied and investigated with the aim of utilizing its powers to the fullest extent. Indeed, it offers advantages that demand more careful judgment than mere consideration of decoration and beauty. In the hospital, traditions of cold institutionalism are being overcome. Convalescence is being furthered by environment as well as by diet and medicine. In schools, attractive, cheerful surroundings are being used as aids to study and concentration. In offices, industries, colour is being employed to counteract the depressing monotony of drab, uninteresting surfaces that not only create discontent but make for business inefficiency as well. Every year we are finding out how we can obtain better crops by means of the application of coloured rays. The meterologist has taken up the colour of the sky as an indication of weather, and is making exhaustive tabulations of facts in order to make more definite the lore which we learned as children in such rhymes as:—

"Evening red and morning grey,
Sets the traveler on his way;
Evening grey and morning red
Brings down rain upon his head."

Since colour influences the emotions and creates a proper mental attitude, it is as essentially important in life as sanitation, proper ventilation and light, and the various things that make for a healthful normality.

In home decoration, the good use of colour should include more than a desire to lend charm and outward agreeableness to the eye. The things that have been accomplished by way of an emotional application are worthy of every thought. Colour should be used by all means. But it should be used with attention to its mental forces as well as aesthetic. All this is true in its application to clothing, also.

Colour is emotional. It appeals to the mind as well as to the eye. This is an important fact to remember. Red differs from blue in stimulation as well as hue. One is enlivening in its

effect, the other pacifying. The warm hues, red, orange and yellow, are active, vital, invigorating. The cold hues, blue, violet and green, are subduing and passive. Here one finds opportunity—a force that should be put to service and not neglected or weakened through haphazard application. Taking the entire run of hues in an order in which they exist in the spectrum, a discussion of each colour reveals many interesting facts.

Red, first of all, is the most vivid and powerful of hues. In coloured light it has greater visibility than white. When exhibited at full intensity in large areas it is almost unlivable. Yet, in some applications it is most cheerful; it is warm, glowing, human. It is the colour of the blood; hence, is it surprising that red is the colour denoting life and action, cheerfulness and enthusiasm? Red is used by healers as a powerful stimulant and tonic, thus it has the meaning of health and vigor. This is why nearly all red stones are said to have health-giving and disease-preventing properties. We find the healthy man is inclined to be more cheerful than the sickly man; so we instinctively think of Mr. Greatheart as a man with rosy cheeks. The garnet has nearly always been said to bestow the gift of cheerfulness upon its wearer. Then we find the healthy man is usually more courageous and daring than the weakling; hence red often means courage. In tints the colour red is anaemic, but in shades it is comfortable and consoling. In a den, a library, a room of intimacy where a mild stimulation of the mind is desired, red can be used with wonderful results. It is warm, aggressive, potent, enough to create an atmosphere of friendliness, joviality and all the livelier moods. While it is limited as a wall covering to duller tones, there should be at least one bright spot of its brilliance in plain view to stimulate the heavy spirit and counteract the depression of the drab day. Red should have a place in every home and every wardrobe, just as today it is granted a place in five out of six flags of Christian and Oriental countries.

Orange also is brilliant, but not as sophisticated and worldly as red. It is quick to the eye and quite glorious, inasmuch as it is the hue of gold and many polished metals. As it does not have the strong vividness of red, it can be applied in fuller purity. The sun-parlor or bedroom are made more delightful with it. Rooms of north exposure can be made more "sunny" with its use. Orange heightens the spirit. It has strong and vibrant appeal. If red makes a room human, orange makes it happy. It is bright, fantastic, and it lends charm not to be duplicated by any other hue.

Yellow as a colour is full of legend. It symbolizes the sun, is the lightest of the hues, and serves an excellent purpose where luminosity and visability are needed. Curiously, yellow is a despised colour in Christian countries, being confined in heraldry almost exclusively to the Pagan and Oriental. Yet, prejudice aside, yellow has been given large preference in buffs, tans and ivories. Because of its high reflective qualities it brings brightness into the home—on the ceiling, walls, and woodwork. Deprived of purity, it has not much emotional exhilaration. However, yellow in full intensity is a clean, luminous colour. It is also "sunny." It has a good place in the kitchen, the bedroom, the nursery. When its texture is made shiny or metallic, as in pottery, it has a certain air of refinement and daintiness that is attractive. In this application it can find a good place in the living room wherever darkness is a handicap to be met.

Of the cold colours, green above all is the most versatile. It is a colour of nature, refreshing without being monotonous, and lively without being presumptuous. As it can be shifted to yellow or to blue, its emotional force can be made mellow or cool. Green is an excellent colour in the living room. It is pleasing to the eye, comforting to the emotions. It is valuable where restfulness is desired. It stimulates harmony, though perhaps a bit subtly. In bedrooms with south exposure, green tints "soften" the heat and brilliance of the sun with agreeable effectiveness. In fact, green is an ever-satisfying hue, in its tints and in its shades, and has a year-'round appeal. It has no artificiality about it as with other colours.

Blue is a hue that is highly pleasing in small areas and highly depressing in large areas, especially when of maximum intensity. It is full of legend, and greatly favored as a colour of personal choice. It is one colour that should be applied in the home with considerable care. Large, flat areas of it should be avoided, particularly in strong purity, and it should be watched carefully in rooms that have long and steady occupancy. It is known to produce melancholia. The eye finds difficulty in focusing blue. Consequently it has a distressing influence. The opposite of red, it can throw the spirit to monotonous depths with its cold, relentless clarity. Yet, judicially applied, it is an attractive hue. Touches of blue lend relief and coolness to the room. Because of its physical properties—it is the most transparent of colours, like sky and water—it stimulates ideas of cleanliness. Blue is not an earthly color. It is removed from the sophisticated and in heraldry signified sincerity, hope and truth.

Violet is comparatively a new color, in pigments as well as vision. It is a hue rarely encountered in nature in full purity. There is a certain daintiness and dignity about it that has kept it close in the mind to ideas of femininity, pomp, splendor, royalty. Here is the color for the aesthete, a hue for the music room, for the boudoir, the salon. In tints it has pleasing emotional powers. In purity it is best confined to small areas, as it stands next in order to blue as a retiring colour.

Black and gray are outside the realm of

emotion. They serve little or no aesthetic purpose. They are dull and uninteresting unless made attractive through form or contrast. The eye, in vision, accepts black and gray to distinguish tone and value. Beyond this it does not respond. No one can truly prefer gray and give a logical reason. Colour serves little or no purpose in vision. Objects could be distinguished and recognized without it. Yet, it gives vivacity and personality to surfaces, and makes joyful a world that would otherwise be severe and monotonous.

People look to colour not merely to match individual preferences, to exhibit decoration, or to give superficial harmonies to the eye, but to put in the home an element that can be made to play a major part in human contentment. Ideas of strict utility fade away. Plain vanity melts. Colour is a science. It has a definite, measurable value. It is an appealing force to the emotions, and as such plays a significant role in the scheme of life itself.

EDITORIAL

(Continued from page 5)

us two splendid papers by Drs. Sidney Johnson and Edley H. Jones, on Hypertension and Hay Fever, respectively. Vicksburg is getting to be a real medical center and we are always glad to have papers from these boys over on the banks of the "Father of Waters".

Five of our fellow comrades have fallen and passed on within the last few months. Drs. J. F. Aycock, J. Augustus Evans, William Howard Miller, J. S. Voyles, and Chas. Daniel Shipp. We miss them and we regret their going. We reverence their memory. We offer our sympathy to their families, relatives and friends. You will read in the next issue resolutions and a brief sketch of the life and work of each, prepared by the Committee on Necrology, of which Dr. W. A. Johns, of Corinth, is chairman. This seems like a large toll for our society and it is for this short time. But taking the state as a whole, it is not. Up to date this year, the number has totaled about fifty. A large number, nearly fifty per cent, have died of heart trouble. This is a strong warning. We need to practice what we advise: regular examinations once or twice a year, and in some way we need to be relieved of some of the stress and strain which comes to us in more than a double portion.

Dr. J. W. Price, of Booneville, and Mrs. Velma Holley Gilbert were married on the 14th. Mrs. Gilbert is a member of the well known and splendid Holley families of Prentiss County. Dr. Price is a son of the late distinguished and beloved Dr. D. T. Price, of Booneville. Dr. Wesley practiced with his father in Booneville for a while and then did eye, ear, nose and throat work in Memphis for a number of years, where he was recognized as one of the leaders in this special branch of the profession. He has not been engaged in active practice for the last few years. We offer our congratulations to this splendid couple.

No other profession has made such progress within the last fifty years as has the medical. Scientific facts have been multiplied over and over. The science of medicine in its entirety is too much and too big for any one mind, and yet it is so interwoven and so closely related that to know one division it is all but imperative to know all. Specialties in the profession have been multiplied. It has been necessary, for the benefit of the public and the satisfaction of the profession, to specialize. But the indications are that specialization has been carried too far. At any rate, the general practitioner and the general surgeon have been relegated to a back seat. Two things have happened—the price of the specialist has been burdensome to the general public, and the science of medicine has suffered because there are so few who are able to correlate the limited fields to the general. We either need fewer specialists in the specialities or more specialists in the general. The latter, we believe, are more essential. The general practitioner may come back to his own if he keeps himself professionally fit. He is needed by the rank and file as never before. He should hold his head high and practice this division of medicine in the most satisfied and dignified manner. He will need to have the help and the advice of the specialists in about one-tenth of his cases. This will be true with the general surgeon as well as the general man in medicine. Under this plan we will not have so many specialists, but the ones we do have will be real and true and of untold value to the general practitioner and to the public. Give us more "general" men who will efficiently pursue their profession with dignity and with satisfaction.

Dr. Hugh Gamble throughout his administration as president of the state medical association emphasized the importance of organized medicine. President Howard, of Vicksburg, comes along and continues to work to this end. He is carrying the idea out to a practical and a working conclusion. He has demonstrated a nice piece of work along constructive lines by calling upon the vice-presidents who have only existed in name before, to help in this work. We were delighted to have Dr. Hoye, Superintendent of the State Hospital for the Insane at Meridian, with us at our last meeting and you will be delighted to read his able and well-written paper on organized medicine in this issue. Dr. Hoye is an able superintendent of this state institution and we were pleased to have him.

"Enriching Human Life Through Form and Color", is a paper that we believe you will read with interest and profit. It was written by Mrs. J. B. Sanders of Booneville, Miss.

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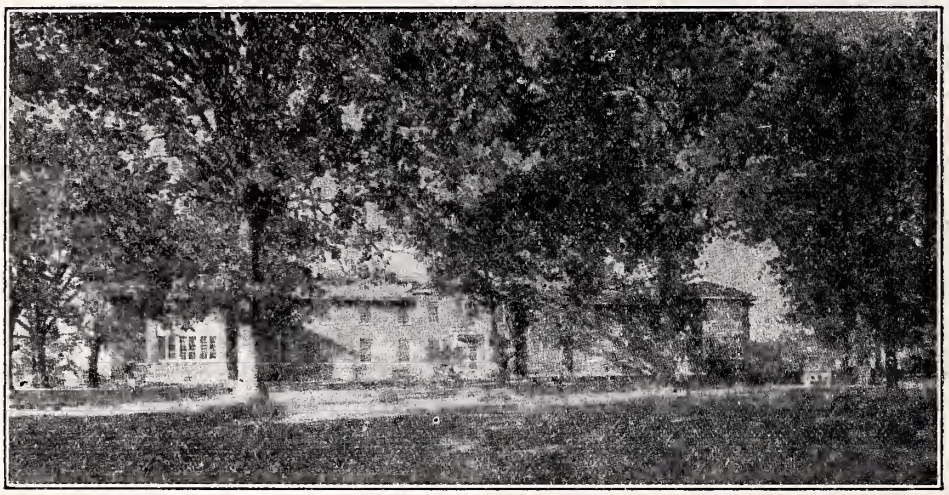

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THE MISSISSIPPI DOCTOR

VOLUME 8. BOONEVILLE, MISSISSIPPI, MAY, 1931 NUMBER 11.

THE N.Y. ACADEMY OF MEDICINE
OCT 11 1946
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Opportunity

They do me wrong who say I come no more
When once I knock and fail to find you in;
For every day I stand outside your door
And bid you wake and rise to fight and win.

Wail not for precious chances passed away!
Weep not for golden ages on the wane!
Each night I burn the records of the day;
At sunrise every soul is born again.

Laugh like a boy at splendors that have sped;
To vanished joys be blind and deaf and dumb;
My judgments seal the dead past with its dead,
But never bind a moment yet to come.

Though deep in mire, wring not your hands and weep;
I lend an arm to all who say: "I can!"
No shamefac'd outcast ever sank so deep
But yet might rise and be again a man.

Dost thou behold thy lost youth all aghast?
Dost reel from righteous retribution's blow?
Then turn from blotted archives of the past
And find the future's pages white as snow!

Art thou a mourner? Rouse thee from thy spell;
Art thou a sinner? Sins may be forgiven!
Each morning gives thee wings to flee from hell;
Each night a star to guide thy feet to Heaven.

—Walter Malone

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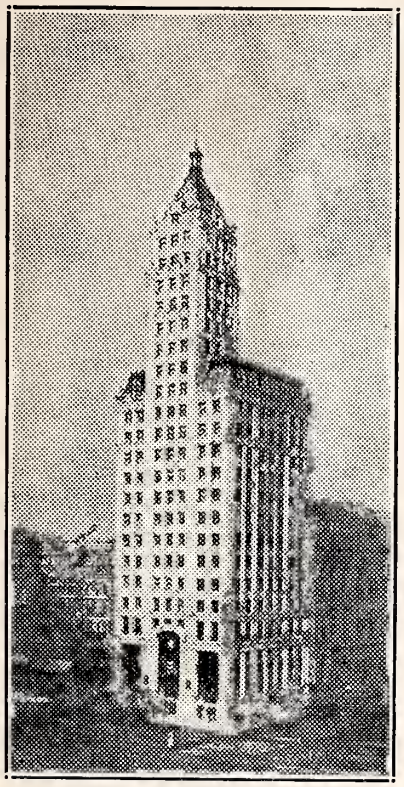

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Spinach,	Asparagus,
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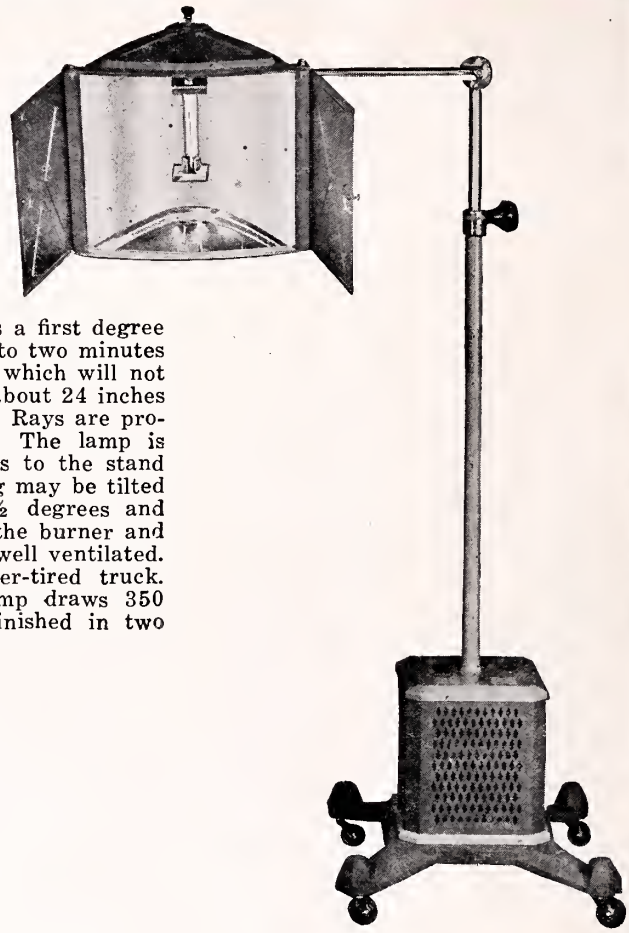

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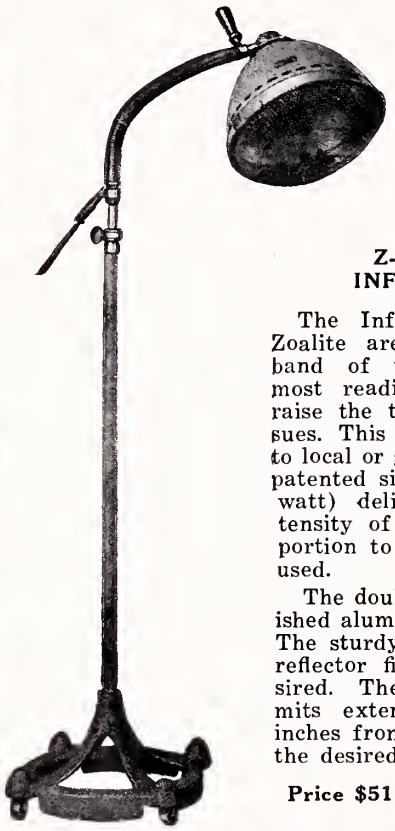

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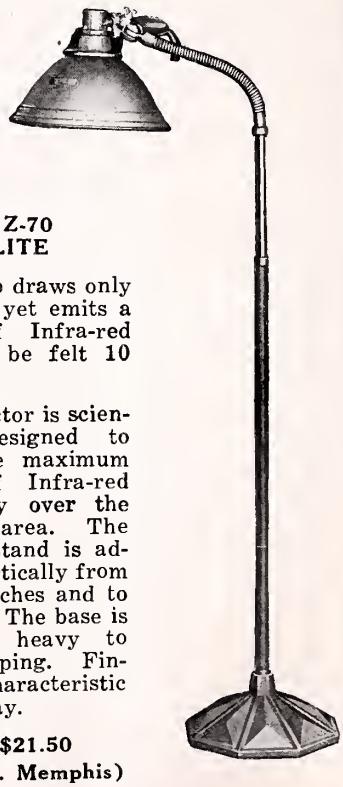

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—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

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You will read a fine list of papers in this issue of the journal. Dr. Speck of the North Miss. Six County has an able paper of duodenal ulcer. Dr. Barnes of the Delta Society, Belzoni, has a most interesting paper, on Check and Double Check in which he brings into play economy, philosophy, and human values in an artful manner. Dr. F. F. Young of Covington, La., has an intersting essay on "Hospitilization of Patients." Dr. Cleveland of Tupelo is not such an orator, but he is a writer from away back as demonstrated by his paper on "Prevention of Diphtheria." Read his Gospel. Dr. Patterson has a discourse on "Organized Medicine of the Future."

It was a great delight to have Dr. Carey of Dallas on our state program and have him discuss an important subject. He is a magnetic and a magnanimous personality; he is scholarly and has and is doing much for organized medicine.

Dr. Gaudet gave us a good section on eye, ear, nose and throat. His out of state essayists were Drs. Stanford and Henry of Memphis. No better men are to be found in the south. Dr. Gaudet did not leave anything undone to make his section a success.

Dr. T. P. Sparks of Jackson put out a very practical section on surgery. Dr. C. F. McCuskey was an outstanding essayist from out of state on his program.

The hospital meeting at the state this time will no doubt result in much good. Next year it will meet the day before the regular session. This will be better. It is the general impression that hospitilization is very expensive and that hospitals lose money. This has been true in the past, generally speaking, but it should not be. If the state takes care of the actual charity in the hospital territory and business methods are used in operating the hospital, and the Golden Rule as well as the Rule of Gold is practiced, a sick patient can be treated in a hospital much cheaper than at home and the hospital will pay a six percent dividend. There are plenty of products going to waste in every county that may be had for the asking to reduce the present price in the average hospital one third and to make a dividend certain. It is just a matter of interest all the people in the hospital and making it serve all alike and serve all efficiently. Every physician who visits a hospital should have an equal show. But this is not the case by any means in a large part of the hospitals. Favoritisms are shown and the prestige of the hospital is diverted to the interest of the few some times. It is a matter of service, business ingenuity, and Golden Rule, and your rates will drop and your dividends will be forth coming. The problem will be solved when it is studied, aired and discussed as it was at the meeting last week. Let every man put his mind to the hospital problem rather than back off and say it is impossible.

Dr. J. M. Acker of Aberdeen, Secretary of the North East Mississippi 13 County Society, is the new president elect. He is a most efficient secretary and he will carry this same efficiency to the state as president.

You will note the half page ad of the Southern Surgical Supply Company of New Orleans. They exhibited at the state meeting last week. They are clever and reliable. We were glad to have them at the state meeting and we thank them for this ad. The medical profession and the manufacturer of instruments and medicines should work hand in hand.

We appreciate very much the full page ad from All States Life Insurance Company. This company is giving us group insurance at a very reasonable price. We are of mutual benefit to each other. We thank you.

The keenest hurt of all wounds is to be misunderstood and betrayed by a man whom you have trusted as a friend.

The medical profession in Mississippi, the South, the entire United States bows its head in grief and regret at the untimely death of Dr. Lynch of New Orleans. He was one of the very ablest nose and throat men in the United States. He was a great teacher, he was an able diagnostician, he was phenomenal as an operator. He was an original and a constructive thinker. He was profound in his simplicity. He was a likable man, quiet, unassuming and sincere. The profession feels deeply his loss.

Dr. J. T. Googe put up a very strong public health program this time. His out-of-state essayists were J. W. Cox of New York, L. L. Lumsden of New Orleans and King Wade of Hot Springs. They are all outstanding men. We were especially glad to have King Wade. Mississippi feels a great pride in him and his work. He subscribed for "The Mississippi Doctor" for several years ahead. We thank him for this.

Group liability insurance was adopted by the association at the last meeting. This was a constructive piece of business. If we have only fifty men to take it under this plan twenty five percent will be saved. If two hundred take it thirty percent will be saved. And in addition to this efficiency should be increased.

The South feels exceedingly proud of Thomas M. McMillian, of Philadelphia. We were greatly honored to have him on our program. He is an outstanding authority on the heart. He is a native of Mobile, the long settled city of culture and refinement and Southern chivalry. From this atmosphere these qualities have inately possessed him. He was accompanied by his versatile and charming wife.

If a plan can be worked out where by the relatives and friends of charity patients who come along to the hospital and remain round about can be put to work during this period, the charity problem with hospitals will be largely solved. You can usually tell a charity patient by the multiplicity of those accompanying.

The Section on radiology presented an unusually strong program this time. It is now a part of the regular association and rightly so. Interest is growing in this department very rapidly. Dr. Nichols of Cleveland was the out of state essayist.

Now that the state medical meeting is over the eyes of the medical profession are turned to Houlka for the next big feed of mental and physical food. Daddy Walker will be in charge assisted by his co-worker Dr. Hood. Dr. Walker is the silvertongued orator of the North East Mississippi Medical Society. He is not only able and resourceful in the spoken word, but has been known for some time for his pronounced social activities. He is a heavy and a systematic courter, but does not mean anything by it. We have never been to Houlka, but Dr. Walker says that Pontotoc and Houston are suburbs of it. It has sent out many doctors, twelve or fifteen we are informed. We understand this town is made up of very clever people. They will entertain royally. Distinguished speakers will be present. Our sister society, The North Mississippi Six County has been invited and we expect this to be a joint session. In attendance this meeting will do doubt over shadow our state society. If you miss this meeting it will be your loss. June is the month and Houlka is the place. We will have more to say about it in the June issue.

PAST, PRESENT AND FUTURE PRESIDENTS

Dr. E. F. Howard, president of the State Medical Association, did a lot of constructive work during his tenure of office that has just closed. A man who can make a vice president a dynamic power in an organization deserves a lot of credit. Dr. Howard did this. He did many other things for the benefit of organized medicine in Mississippi. His administration will bear much fruit. As chairman of the "suggestion committee' Dr. Frizell has done some very valuable work. The change to allow thirty minutes to out of state guests and to limit each section to two men was very wise. The provision to provide three names to be voted on by the house of delegates for the council and other officers will improve the general health of the association. In short, and in a few words, great progress was made this time to give the rank and file a chance and to enlist the entire membership of the association. There is much more work to be done along this line.

Dr. J. C. Culley of Oxford is now president of the State Medical Association. He announced that two aims of his administration would be to assist in bringing modern medicine to the rural communities by way of the small hospitals throughout the state and to engage the interest of the entire medical profession of the state in our medical department at Ole Miss. Dr. Culley is a fine example of what may be done in a small town. He is a general surgeon of fine ability. He has operated a hospital for a number of years and has done it very successfully. Dr. Culley is distinguished throughout the South for his success in spinal anesthesia. He is a good organizer, a tireless worker, and is diplomatic. He has administrative ability, is cultured and versatile. We predict great progress in the association under his direction.

FROM HERE AND THERE

The sectional divisions of the state meeting enjoyed some very distinguished men this year: Dr. McMillan, of Philadelphia, Pa., Dr. Cary, of Dallas, Texas, Dr. J. W. Cox, New York City, Dr. Nichols, Cleveland, Ohio, and Dr. McCuskey, from Rochester, Minn.

We are proud of the new vice-president from our section, Dr. Speck, of New Albany. He will be an able man in the work.

Dr. Seale Harris, from Birmingham, was a visitor at the state meeting. He renewed many old friendships and was greeted warmly by his Mississippi friends in whose esteem he holds a high place.

Members of the profession who have long known Dr. Vandiver, of Baldwyn, regret that he is still in a serious condition at the hospital in Booneville, where he underwent an operation for gall stones.

Dr. J. M. Acker, of Aberdeen, is having a fine job of remodeling done at the old antebellum home he wishes to modernize yet preserve its original charm.

Everybody is getting ready for the next meeting of the Thirteen County and Six County Medical Societies in Houlka. Dr. Walker will be the host.

Among other out-of-State guests and visitors who attended the State Medical Association in Jackson are: Drs. Priddy, Stanford, Sanders, Blassingame and Rowland, of Memphis, and Dr. Lyons of New Orleans, fraternal delegate from Louisiana.

Miss Vivian Crouch, of Booneville, returned recently from a thorough nurse's training course in New Orleans. She has also trained in St. Louis.

Hospitalization of Patients*

"My Fifty Years of Observation and Experience."

By DR. F. F. YOUNG,
Physician-in-Chief Fenwick Sanitarium,
Covington, Louisiana

When I look back, observe and realize the wonderful progress and advancement that has been made in medical colleges as well as in the operation of hospitals, I sometimes have to rub my eyes and open them wide, to see if it is not a dream. The proper hospitalization of patients implies one cardinal principle, "Service," this of course results from proper executiveness, kindness and financial backing. Fifty years ago, the great Charity Hospital in New Orleans had only one chief surgeon, one assistant surgeon, ten interne students and a few sisters of charity to make up its entire staff; such a thing as the service of this day was unknown, graduate nurses, either male or female, did not exist in America and ambulances were entirely unknown, can you conceive this? In the wards, as soon as patients were sufficiently convalescent to assist or wait upon the more seriously sick, they were required to do so and especially in the male wards this always resulted, in the majority of instances, in these individuals slipping out, between suns, as quickly as possible. We were taught and impressed with the fact that Chloroform was the anesthetic par excellence, for the southern states and that ether was the most desirable for the North and East, any form of local anesthesia was not practiced, cocaine was unknown. Our great State Institution, old Charity of New Orleans stood proudly as the second largest hospital in the United States, Bellevue Hospital of New York was larger than it by only a few beds.

Completing my medical studies, in New Orleans, I entered as a student at Columbia and had the opportunity of having as teachers such illustrious men as John Dalton, John Wyeth, Marion Simms, Austin Flint, Loomis, McBurney, Delafield, Bull, Thomas and Halstead and I became an interne student at Bellevue. While more theory was taught here than I had gotten South, yet these professors had nothing over our Bemis our Jones, our Logan, our Richardson, our Miles, and our beloved Lewis. Here let me transgress, to say that I assisted in the first laparotomy successfully done in New Orleans by that grand old man, Professor Ernest S. Lewis, living yet today, the case being one of Hystero-catalepsy for which Dr. Lewis removed ovaries, believing that reflex irritation might have been the cause. In eighteen hundred and eighty one, McBurney brought a sample of Iodoform gauze from Lon-

*Read before Louisiana State Hospital Association, Baton Rouge, La., April 22, 1931.

don and demonstrated it to the student-body, speaking of it as a wonderful achievement in "Listerism," Sir Lord Lister, having made the first advancement in antiseptic surgery, aseptic surgery was unheard of and unknown. In New York City, the great "Woman's Hospital" had small one room brick houses, in the yard, where all abdominal work was done, these houses or rooms being copied after the fashion of those built by the late Battey, of Rome, Georgia. In each corner of these one room affairs, was a steam atomizer "puffing" forth carbolized water, carrying infection instead of preventing it, as we then thought. These atomizers were put in action just before an operation would be performed. The surgeons entered these rooms ready for work, always wearing a Prince Albert coat, and the only precaution taken was a small front apron, put on each surgeon, more to protect the Prince Albert coat than the patient. In the lying-in wards, the chief obstetrician would come in and when he found a case of puerperal septacemia, he would make a vaginal examination, with his naked fingers and afterwards rinse them with a little warm water and soap, examine the next lying-in woman and thus go from bed to bed, and can you believe it, we were surprised that all of these unfortunate woman should develop septacemia and rapidly die, with few exceptions? Today, I bid you sit back and get the panorama of the picture as registered on your cortex, showing the wonderful accomplishments and achievements made since those days in our great medical schools and state hospitals. Of private hospitals then, there were, indeed, very few, either general, or neuro-psychiatric. Any other special hospitals did not exist. In those days too, due to our "antiquated" medical ethics, a young physician or surgeon had no chance of bringing his genius and accomplishments to the fore, for suffering humanity. He had to wait until he was ripened with age. Here too, in this day, as in our other advanced methods, age no longer counts. Some of our most wonderful men in the medical profession, wonderful executives, in the management of our immense hospitals, are physicians or surgeons, under thirty five years of age. Right in New Orleans, we have an example, that splendid young surgeon, under thirty five years of age, big of body yet bigger in brain matter, as chief executive of the great Charity Hospital and Dean of the splendid medical school, being born to the Louisiana State University. Today, his genius is recognized, without regard to his years. Go through the Charity Hospital and see the many changes and improvements, for the betterment of suffering humanity that Dr. Vidrine has made, then turn to the selection of his faculty, for the new medical school, and you feel compelled to say to yourself, at last, we recognize the fact that we can get many years of the best in him, before he reaches the age, which we once thought was necessary for "ripeness" of judgment and when he reaches that age, he can still carry on as well, if not better, than ever. And on down the line of progress, for suffering humanity, many such instances can be cited.

Coming nearer the subject-matter of this paper, from my observation, as Head of the Fenwick Sanitarium, an Institution devoted exclusively to mild mental and nervous diseases, in which I have been physician in chief, for thirty-eight years, I wish to plead for more cooperation and affiliation between the chief executives of all of the hospitals of our State, and even those of the neighboring States. We need closer communion and this will certainly redound to the help of those requiring hospitalization. We live in an age that moves and where industries and sciences are divided and classified into various specialties, of their respective departments. When I was a young physician in the East there were specialists, in different branches of medicine and surgery, but none existed in the South. In the great City of New Orleans, which I predict will soon be the largest sea-port in America, it was only in eighteen hundred and eighty four, that the first ear, nose and throat specialist appeared. Today finds us specialized in the departments of the practice of medicine and surgery but we have yet, many "hybrid specialists" in our ranks and we can only expect to improve this condition of affairs by organized medicine and so, too, by the thorough organization of the executives proper of the many hospitals and sanitaria. These latter will function in such a manner that before we realize it they will be properly divided separately, either the larger institutions into special departments or into separate "special hospitals" for classification of patients. This means for the better hospitalization of every individual, requiring the assistance of medical science. Of course we shall not see this, but I believe, generations to follow us will have hospitals and sanitaria operated in every community for the ailments of mankind and the monetary cost will be such that whenever there is sickness in any private household, of that community, the patient will be immediately transferred to the local hospital or sanatarium so located. And why shouldn't it be thus? For we all know how unsuccessful are the surgeons and physicians of today in having their instructions caried out in private homes, even among the wealthy and even when supplied with graduate nurses. Here let me call attention to the definition of the words Sanatorium, Sanitarium, and Hospital. Many physicians use th m synonymously but this is erroneous, a Sanatorium is a place where people who are well go to keep well. They are usually operated around spas and springs. A Sanitarium is an institution where ambulatory patients go to get well and convalesce. A Hospital is an institution where people sick unto the bed go for medical and

surgical attention, the patients being afflicted with both acute and chronic diseases. As a general division, we might classify hospitals and sanitaria into two classes: first, the charitable and state institutions and secondly, institutions operated under private ownership.

From my observation, it is my opinion, that all charitable and state institutions should be constructed on the pavillion plan, with one administration unit or building. I make this statement, because these institutions do charity for every kind of disease known to mankind and by the pavillion system, I feel the individual, so confined, will get by far the best hospitalization service, because being in separate buildings he would be classified according to his respective disease and thus relegated to himself and freed from the annoyance of other patients. Right here, don't be surprised when you hear me say that I wonder, Just wonder, if that great medical center, the greatest in the world, known as Columbia University, has not made a mistake in crowding its buildings together, having the Sloan Maternity, the Roosevelt, the Neurological and other hospitals, altogether in one bunch, over a small amount of ground, might it not strike you that it might have been better to have adopted the pavillion system, controlled and operated through a one unit administration building? In these immense buildings, different floors are allotted to differently classified diseases. May I ask you, would it not have been better judgment and more advanced medical science, to have had, instead of these sky scrapers, entirely separate buildings under the pavillion system? Of course, in this great medical center, finances were not wanting and almost anything could have been accomplished, in this instance, but in many others, finances, which control the working of every hospital, whether it be private or otherwise, is the prime factor in its operation and the chief executive is compelled to do the best he can under the circumstances. Take for instance, our East Louisiana and Central Louisiana State Hospitals, where the patients are not properly classified and put in separate buildings. We are bound to admit, that if done, it would redound much to the advantage of each individual case. In Middleton, Conn., some years ago, I visited the State Insane Institution there, in which were six thousand patients, each division of mental diseases being classified and separated from the others and it was beautiful and inspiring to see such a mass of demented humanity, under perfect control even to the strike of the clock.

In conclusion, I am strong for the centralization of our general hospitals, whether operated for charity or otherwise and where finances afford, believe they could be operated to the better advantage of individual patients, if under the pavillion system of hospitalization. Especially do I believe likewise, that all hospitals for mental and nervous diseases should be under the pavillion system, despite the fact that the institution, of which I am chief, has not yet advanced to that point. Remember I state that finances controlled the development of these problems.

Duodenal Ulcers

By DR. C. M. SPECK
New Albany, Miss.

From records of my examinations Duodenal ulcers are increasing in frequency and most authorities agree with this statement. The Clinical diagnosis of Duodenal ulcer has been chaotic until recent years. In former years reference was made often to gastric ulcer but seldom to Duodenal ulcer, however, we know now that duodenal ulcer is three times more frequent than gastric ulcer. Most of the ulcers in the vicinity of the pylorus, which have been called Pyloric ulcers, are in reality duodenal ulcers. Mayo's statistics show 73 per cent duodenal ulcers to 27 per cent gastric ulcers. Duodenal ulcers occur three times as frequent in males as females. Krauss gives a ratio of 10-1, Robson-Wier 6-1, Mayo and Graham 2½-1. In Mayo's series of cases the proportion of cases of duodenal ulcers to gastric ulcers stood 275 to 108. German authorities say that out of 600 autopsies of both sexes and all ages, death being due to various diseases, showed that 8 per cent of them had duodenal ulcer. There is an increase in the frequency of duodenal ulcer, no doubt, pending reports all over the country, by various Clinicians. Duodenal ulcer is not infrequent during the first year of life. It seems to be due to any condition which greatly weakens vitality, such as long suppuration, sepsis of any kind, rachitis, nephritis and primary marasmus, and in children who have had extensive burns. Of course duodenal ulcer is more frequent between the ages of thirty and fifty.

There is a strong tendency of those who are predisposed to tuberculosis to develop duodenal ulcers. A large per cent of them occur in patients who have a tendency toward visceroptosis. The cause of duodenal ulcer has been much discussed and a lot of research work has been done in various clinics over the country but the work of the Mayo Clinic is outstanding in my opinion. Rosenow of the Mayo Clinic has demonstrated some very interesting facts in lower animals. He has shown that infected teeth, tonsils and pyorrhea artificially infected, produce almost invariably ulcer bearing animals. He has shown that animals in one instance of focal infection may have ulcer, another may have appendicitis and another cholecystitis, and infective material taken from the abdominal disease, reinfecting another animal, in one instance may cause appendicitis, in another gastric or duodenal ulcer or another cholecystitis. In other words the results are uniform, but selectivity of the streptococci may be different in different cases; showing conclusively, that these diseases are due to infection and that this infective material in the majority of instances, is of the streptococci bacteria, usually

of a mild type.

This leads us to the predisposing cause of duodenal ulcer. The question comes to our minds, why does the stomach or duodenum not digest itself? The gastric juices will digest proteids of non-living cells, then what keeps the stomach from digesting itself? There is something produced from the living cells of the stomach, that is peculiar to those cells, that counter-acts the action of the gastric juices. We know from abdominal operations that the pancreatic and gastric juices will digest living cells in the abdominal wall. Let us call this counteracting substance, excreted by the gastric or duodenal mucosa cells, Anti-enzyme.

Again we know that the most frequent sites of these ulcers occur where the circulation is the poorest in the stomach and duodenal walls so you can see that anything that would impair this circulation, as over-eating and inherent predisposition, would at once bring about an alteration in secretions of these mucosa cells, thereby, altering this Anti-enzyme, leaving the mucosa free for digestion and infection. Then we readily see why most of these ulcers burrow beneath the mucosa and give us the characteristic crater-like ulcer, as the juices have a freer action in submucosa than on the mucosa because of the properties of the mucosa in producing the anti-enzyme that counter-acts the gastric juices.

I desire to call your attention, in regard to symptomaltology and diagnosis, that the history is most important, the X-ray second and gastric analysis third. In fact gastric analysis is of very little importance in the diagnosis of duodenal ulcer.

There are few diseases in which the symptoms appear in such definite and well ordered sequence, however, the value of one symptom may be dwarfed or destroyed by the preponderance of another symptom. The patient may complain of indigestion, acid dyspepsia or sour stomach and be very positive in the statement that this has lasted over a number of years with alternate improvement and relapse. The symptoms are more persistent, as a rule, through the damp, cold seasons of the year and probably the most important diagnostic symptom is hunger pain. In some instances this extremely marked, coming on from two to four hours after meals and being relieved by food. If the diet be light the pains uniformly come on earlier. The converse of this is likewise true.

Of course when a duodenal ulcer has formed a great deal of scar tissue and cicatricial contraction the symptoms are then those of retension and delayed motility. This depends upon duration of the lesion. The time of the onset of pain in duodenal ulcer is much more constant than that of gastric ulcer and almost invariably begins from two to four hours after eating. This is due to free hydrochloric acid coming in contact with the ulcer which produces an exaggeration of the reflex motor efforts which produce pain. When we realize that the glands of the stomach that produce hydrochloric acid are situated in the proximal two thirds of the stomach, while the pyloric end is usually alkaline, the chyme remains constantly acid and the cardiac ulcer is bathed in the acid gastric juices at a very early stage of digestion. The food which reaches the pyloric end of the stomach is alkaline and it is only after a considerable interval that the acid gastric juice reaches the pyloric end of the stomach. Consequently, it is from two to four hours before sufficient free acid passes over the ulcer to produce the exaggeration of the reflex motor effort which produces pain. Hunger pain occurs in all the series of 146 cases ranging from two to four hours after meals. Overwork, anger and chilling of the body are liable to bring on attacks of pain earlier. Therefore, according to Myonihan, stomach trouble lasting for years, with hunger pains relieved by food or soda, with severe exacerbations followed by periods of almost complete freedom from discomfort, almost always indicates duodenal ulcer. The patient is also likely to complain of a sense of epi-gastric oppression, weight and distention, especially an hour or so after taking food. He is also prone to manifest a nervous phenomena which we are familiar with in hyper-chlorhydria such as insomnia, general irratability, loss of weight etc. His appetite is often very good, nausea and vomiting is very frequent during the quiescent period which may extend over weeks and months. Suddenly there may be a return of an occasional vomiting of blood, tarry stools or there might be the evidence of perforation.

To summarize the symptoms, the patient states that he has certain definite attacks, nearly always worse in winter than summer and very apt to be precipitated by a chill. From two to four hours after breakfast he is fairly comfortable, then the stomach feels full and heavy, he may get some relief from belching gas. Some of these patients bring up a sour fluid which tastes very bitter, the pain gradually increasing until next meal time. The patient sleeps very well until about two o'clock then he wakes up with distress and usually eats or nibbles a biscuit or cracker and gets relief. Taking an alkali relieves the pain. If these symptoms are recurrent one can almost be positive of duodenal ulcer.

But we have a few cases that do not have these classical symptoms and weakness and pallor are probably the only signs of any trouble. In that case we have to resort to further examination and here is where the value of the X-ray is important. Of course some clinicians desire an X-ray in all cases to confirm their findings from the history and physical examination. In a majority of instances X-ray study shows an excessive motility of the stomach with a rapid evacuation of the stomach contents. The main importance in X-ray study is first, to confirm the clinical diagnosis, and second to ascertain the extent of the lesion, the size of the ulcer and the motility of the stomach. It is not my in-

tention to go into a detailed description of the actions of the stomach as seen through the floroscope in the different types of ulcers of the duodenum but suffice it to say that a great deal of information can be gained as to the size of the ulcer, the extent and nature of same, and is a material aid in the differential diagnosis between gastric and duodenal ulcer, also between duodenal ulcer and diseases of the gall bladder and pancreas, tumor formations and cancer.

R. D. Carmen of Mayo's clinic identifies four forms of deformities of the bulb, first the greatly distorted type resembling a small pine tree, second the niche type where the natural crate of the ulcer is visible, third incisuria type, single or bilateral, fourth the very small bulb of smooth contour representing a much contracted duodenum. In addition to these types of deformites he regards gastric hypertonus, hyperperistalisis, hypermotility with the six hour residue, very valuable diagnostic aids.

Treatment of duodenal ulcer is divided into two classes: surgical and medical. Surgical treatment is indicated, in my opinion, only in those cases that have developed to such a degree from scar formation and contraction to interfere with the normal passage of the food through the pylorus. There has been a tendency among surgeons of this country to do some operative procedure, usually a gastroenterostomy, in a majority of cases of long standing, regardless as to whether there is retention or not, which, in my opinion, is indeed poor surgery. These cases should not be operated on except, as I have said, in case of scar formation and retraction to such a degree as will interfere to a great extent with the normal passage of food through the pylorus and then only in case this deviation from normal is sufficient to produce alarming symptoms and in case of perforation.

When surgery is needed, the operation should be gastroenterostomy or repair of the perforation, followed later by a gastroenterostomy if necessary. The chief way in which a gastroenterostomy conduces to the healing of duodenal ulcer is by preventing gastric distension, however, you can secure much the same results by a proper diet, alkalies and atrophine and by giving the food in small amounts at short intervals and using hot water, which will pass quickly out of the stomach and wash and cleanse the ulcer, when the stomach is empty.

I am not going into details of the diet or the alkaline substances used because I think every doctor is familiar with Sippy's diet and powder for duodenal ulcer. However, I wish to state that a proper belt to support the lower abdomen should be worn constantly. A daily dose of olive oil should be taken and the patient should fast every morning, provided it agrees with him. In case of hemorrhage the patient should be put to rest in bed and on strictly a milk diet for at least a week. Dilute nitric acid is indicated in from ten to fifteen drops before meals in half a tumbler of water. Morphia is indicated in hemorrhage from the duodenum, ice pack on the abdomen, and strong purgatives or purgatives of any kind are contra-indicated for the first few days. Horse serum is indicated in extreme cases of bleeding.

The main points I wish to stress in this paper are:

First, the frequency of duodenal ulcer, especially in men between the ages of thirty and sixty.

Second, the importance of the history and the well ordered sequence of symptoms, which will lead you to a diagnosis in 95 per cent of the cases.

Third, the importance of medical V. S. surgical treatment in a majority of cases.

Fourth, diet, rest and perfect control of the patient are necessary prerequisites in treatment of duodenal ulcer.

Fifth, when surgery is indicated, waste no time in refering the case to the surgeon because much damage can be done by procrastination and the change for a cure is correspondingly lessened as the delay in surgical interference.

Prevention of Diphtheria

By W. H. CLEVELAND, M. D.
Tupelo, Miss.

Diphtheria like some other contagious diseases, took an extremely heavy toll in deaths up until a few years ago, when antitoxin was introduced for the treatment of the disease. This remarkably lowered the death rate. Then came the introduction of toxin antitoxin for the production of immunity, and the Schick test for susceptibility. This has enabled us to still further combat the disease, but our morbidity rate is still too high, and as long as the morbidity rate is high, we will have a certain number of cases in which the physician is called too late to give relief, and thus cause the death rate to remain high.

Diphtheria is caused by a specific organism, the Klebh-Loffler bacillus, and has an incubation period of from two to seven days. It is more prevalent in cold weather, and rarely occurs in the tropics. Whites are more susceptible than negroes. Sex plays no part. From five to seven is the most susceptible age.

The infection may be transmitted from one person to another by direct contact or by exposure to droplet infection. It may also be transmitted indirectly by contaminated clothing or use of the same drinking cup, or the infection may be carried in foods, especially milk. It is spread mainly by the active cases, recent convalescents, mild and missed cases, and carriers.

The development of cases is determined first by contact with a virulent strain of the bacilli, and second, by susceptibility to the disease. Then prevention depends on avoiding contact with the infection or overcoming susceptibility by the production of immunity. A great deal

can be accomplished by proper isolation and care of clinical or active cases and convalescents. But to discover all the mild and missed cases and chronic carriers seems at yet impractical.

It is known that a certain percentage of the population at large harbor the diphtheria bacilli in their nose or throat, even though they have had no known association with the disease. This percentage varies from three to ten percent. However, the surveys recorded in the literature on this subject place the percentage much higher in families, schools, and other groups where the disease is known to exist, or there have been known contacts with cases.

The most dangerous carriers are those who harbor a virulent strain of bacilli, and this is usually obtained from the patient, convalescent, or from a third person who has come in contact with the patient. The danger decreases the farther the carrier state is removed from the patient.

Since the avoidance at all times of contact with the infection seems impossible, the determination of susceptibility by Schick test and production of immunity, use of toxin antitoxin, or toxoid play an important role in the prevention of diphtheria.

Our work in Lee County has been fairly satisfactory among the population from five years on up on account of being able to reach these children in school. This work has been carried on quite extensively in the schools, and very good records kept, and in this connection, I wish to give you statistics taken from our records on the Schick test of one thousand four hundred twenty-one white children in all the Tupelo schools and some few of the county schools. These tests were given the latter part of September and in October 1930, and in schools where Schick tests and toxin antitoxin had been administered regularly for the past several years, and last work that had been done on this group was in an average of about ten months previous to the date of this test. All children with previous negative Schick reactions, as shown by our records were eliminated, and they constituted a very large percent.

Age group 5 to 9 inclusive	Number tested who had had no toxin antitoxin ..... 859 Positive—377. percent positive—42.
5 to 9 inclusive	Pos. Schick 1929 or 10 mo. previously, followed with 3 doses of toxin antitoxin 278 Positive—49. percent—17
	Pos. Schick 1928—3 doses. Pos. Schick 1929—3 doses—23. pos. 0—0
10 to 14 inclusive	No. tested who had not had T. A. T. 178. Pos.—60 percent—34
	Treatment T. A. T. 3 doses each 81. Pos.—13 or 17 percent
10 to 14	Pos. 1928 3 doses T. A. T. Pos. 1929 3 doses 2. Pos.—0—0.

According to the above figures, 42 per cent of children from five to nine and 34 per cent from ten to fourteen who have not had toxin antitoxin, are not immune to diphtheria. Eighty three percent of susceptibles in both age groups are immune after three doses of toxin antitoxin. The other seventeen percent are immune after taking six doses of toxin antitoxin.

It is our policy to test all children from five years on up before giving toxin antitoxin, then give three doses to those who have a positive reaction. Children from six months to four years are given four doses of toxin antitoxin with no previous test. At the end of six months after the administration of T. A. T. or as soon thereafter as is practical, we give the test and more toxin antitoxin when needed, as indicated by the test.

We use no control in administering the test and wait until the sixth or seventh day before reading in order to give all the pseudo reaction time to disappear, and all slightly positive or showing any reaction at all are called positive and toxin antitoxin administered.

We had twenty nine cases of diphtheria in Lee County in 1930, and as to age groups they occured as follows:

5 years or younger (none were under 18 months of age) 18 cases.

6 to 10 inclusive 8 cases.

11 to 15 inclusive 1 case.

Adults 2 cases.

Of the 29 cases, one had had a previous attack of diphtheria, three doses of T. A. T. followed by a positive Schick reaction. Another case had had three doses of T. A. T. followed by a positive Schick reaction, and had had one dose of T. A. T. on his second course of treatment. None of the other twenty seven cases had had any toxin antitoxin or test for susceptibility. You can readily see from the above figures that instead of having most of our cases in the ages from five to seven as is the case in a population where no toxin antitoxin is administered, we are having most of our cases in the pre-school children who are below five years of age. This is the group we are having most trouble in reaching, and feel that if we are able to do as good work among them as we are the school children, it will be effected largely through the family physician.

Conclusions:

1. Much good can be done to prevent diphtheria by proper isolation and care of active cases and convalescents.

2 Discovery of carriers in selected groups where cases are developing, by making cultures from nose and throats of persons in the group and proper treatment of some. But this is not practical for the population at large.

3. Determining susceptibility of all preschool and school children by use of Schick test and production of immunity in all susceptible children by use of toxin antitoxin or toxoid.

4. Our knowledge of diphtheria as to cause, mode of transmission, and use of preventive measures is sufficient to control the disease.

5. A more thorough and extensive application of our knowledge of prevention, especially with pre-school children, is needed.

Discussion: Dr. Love: Gentlemen, I do not know that I can add anything to what Dr. Cleveland has said. We have made it a practice to do about as he has. Our records show, I believe, 20 percent of the children above twelve years of age show a positive reaction; and 41 persent from five to twelve years show the positive reaction. Last year, 1930, we had twenty-six cases of diptheria, and all of them pre-school children. And none had had toxin-anti-toxin. I believe that the preventive treatment can be made very satisfactory with the co-operation of the parents and schools.

Dr. Bowen: At the Child Health Conference called in Washington last month, it was declared that the physician was not doing his duty. Only fifty percent of the children are being immunized. It is our duty to have them immunized after the sixth month. Dr. Park, in Washington, says that the public is not yet awakened to toxin-anti-toxin. He suggested a somewhat different plan of administration of toxin-anti-toxin. And only one in every twenty-five administered failed to be immunized under this method. Adrenalin should be given the myocardiac child instead of digitalis.

Dr. Anderson: I should like to ask Dr. Cleveland about the Parker Test; what he thinks of it compared to the Schick Test.

Dr. Bryan: Just want to say that I am glad that Dr. Bowen mentioned the fact that certain cases should not be given digitalis. Glad to hear it brought out. But I do not believe he said it should not be given in any case of infection (I refer to Pneumonia which is strictly a case of infection where it should never be given) Don't give digitalis when there is infection because it is a toxic drug itself, and why give additional toxine?

Dr. Barr: I can say that I have never had two cases of diphtheria in the same family within the same year. And I have never lost a case of pneumonia, except during the "flu" epidemic, and I have always treated with digitalis, and am still using it.

Dr. Bowen: Digitalis, when given in increased doses, knocks the heart down to around twenty, just like having one set of brakes on your automobile and you put on another—it works like a double set of brakes. Not long ago we selected ten counties of children and divided them into two groups, selecting all of one group of the same social and economic status. To the cases of one group we gave digitalis, and had nineteen deaths in one month; to those in the other group we did not give it and had no deaths.

Dr. Cleveland: In answer to Dr. Anderson's question about the Parker Test, I should answer that it is difficult to give properly, harder to detect, and more expensive than the Schick Test. Hence, I believe the Schick Test is better. I want to say that I have enjoyed the discussion by the other doctors of my paper.

Check And Double Check

By G. M. BARNES, M. D.
Belzoni, Miss.

By special permission from Amos 'n Andy the world's most famous Comedians, I have been granted the privilege of using the title of my paper, Check and Double Check. As Andy would say, you may be somewhat regusted before I finish, but however at Amos' suggestion I shall proceed.

Mr. President, members of the Delta Medical Association.

I am going to deviate from the regular routine of discussing such medical subjects as appendicitis, pneumonia, and the injection method of treating hemorrhoids, and stroll for a few minutes, hither and thither, through the garden of memory and reminiscence, and pluck a rose bud here and a leaf there, trusting, when they are placed together, they will be of some benefit to each of us as we journey along life's rugged highway.

I wonder how many physicians before me today have taken inventory of your stock, not of the drugs, instruments, and apparatus you may have in your office, these are merely working tools, but of the stock in trade of new ideas, skill, tact, courtesy, sympathy, and love, things that are really worth while and for which we may expect to reap a reasonable compensation. Such an inventory we fear in some cases would reveal that we had in our storehouse some shop-worn, out-of-date items, heavy with the dust of carelessness and musty with the mildew of ancient tradition and usage. How can we expect to keep pace with this age unless we keep our warehouse of knowledge full of valuable goods, not the showy, tinselly things, merely to catch the eye, but with genuine medical ideas and a heart full of love, such things that will give continuing satisfaction, year after year. To obtain or secure this fresh stock one should attend his various county and state medical associations, read new books, up-to-date medical journals, and when possible, take post graduate work.

It has been suggested that we doctors charge too much for our services. This, of course, is absurd. You are familiar with the story of the fellow who called a doctor to take him home at night as his charges were cheaper than taxi hire. There is no more reason why the public should have a claim upon the highly skilled medical service than there is that it should be furnished free with crepe de chine undies and strawberry short cake. We should be ethical in all our dealings with our professional brothers at all times; no price cutting or fee splitting. There is not a doctor present who will not again and again give his services gladly to the real poor and needy, especially to women and children. And such a wonderful reward we all have received from some of these cases when we have heard that godly mother exclaim, "Thank God and the good doctor, my child has passed the

crisis and will soon be well again."

All human society needs improvement—heaven knows!—and the medical profession is only a cog in that great machine. But we doctors are bitterly opposed to being uplifted by some outsider. If the medical profession is to rise, and it shall, it must come up like the loaf of bread, due to the yeast inside, rather than being carried up like a bucket of mortar. If every medical man gave every patient the thorough, conscientious examination he deserves, thought of his patients and his profession first, and his own comfort and convenience second, the public would not be crying for various quacks and cheap clinics. There has been a lot of talk about helping the poor, down-trodden doctors. Nothing so far has been done, but, in my humble opinion, unless we sit up and take notice it won't be long before something will be done for us, in the form of State Medicine, or worse still, government controlled medicine. Let us quit criticising the mote that is in our brother's eye, but rather, remove the beam from our own. Bear ye one another's burdens, and thus fulfil the law of love.—Check.

This leads up to my next thought: United we stand, divided we fall. It is a slogan that our various county and state medical societies may well take to heart. Municipalities, counties, states, nations, and all societies owe their prosperity to its application. Family ties are controlled by it, for a family divided does not usually accomplish much. The business world would be in a chaotic state if it were not held together by its cohesive force. A great statesman has said we must hang together or hang separately. Because in our own country some seven decades ago we failed to adhere to this warning, there came upon our land one of the worst wars the world has ever witnessed, and one that came very near disrupting this Union. Corporations, fraternal organizations, religious bodies, and all forms of societies would go to pieces if their members were not bound together by the sentiment of union.

Few professions are buffeted about, abused, and at times seemingly as unappreciated as is the medical profession. The public whom we often serve without pay or even expectancy of reward often fails even to grant us an honorable recognition. The main object of our profession is to serve the public and protect it from the ravages of disease and pestilence, in order that health and life may be conserved, to the end that all of us may be useful citizens to our country. It is a well-established principle that credit should be given where credit is due; but witness, if you please, the case of Walter Reed who gave his very life's blood that he might demonstrate the cause of Yellow Fever, and by this discovery saved the lives of perhaps millions of human beings and untold millions of dollars. Only little credit did he receive outside his own profession, a hospital named after him, and his widow after a long time given the modest sum of $150.00 per month. Gorgas, who applied Reed's discovery and made possible the building of the Panama Canal, after the French had spent millions of dollars and sacrificed thousands of lives in a fruitless effort, lies not unhonored, but almost unsung. It is left to his own profession to erect a proper testimonial to his memory. Look, if you please, at the shafts at the tombs of our country's illustrious dead—Washington, Lee, Grant, Lincoln, Forrest, and many others; visit, if you please, the national cemeteries at Vicksburg and Natchez, and behold the wonderful monuments erected to the memory of our country's dead. It would be a poor citizen indeed who would regret a single dollar spent by our government and the various states in erecting these beautiful monuments in honor of her heroes; yet, in all sincerity and with due respect to the memory of our departed statesmen and courageous soldiers, the medical profession in my humble opinion has produced some of the outstanding men through all the ages; men who have done as much, if not more, for their country and mankind than her statesmen and soldiers; men who have been saviors, not destroyers, of mankind; men who not only have faced the dangers of shot and shell, but face daily the dangers of infection as they go about their daily work, trying to help some suffering soul. Take, for instance, Edward Jenner, who by his discovery made it possible to practically eradicate that dreadful disease small pox. Robert Koch paved the way whereby thousands upon thousands have been saved from the ravages of tuberculosis. Louis Pasteur gave to the world preventive vaccination. Lister gave to the world Surgical Asepsis, mind you gave, not sold. Ephriam McDowell paved the way for relief of thousands of womankind. Time will not permit me to name others too numerous to mention. The day will surely come when we shall erect our greatest shafts and monuments, not to the memory of our generals, admirals, or statesmen, but to the guardians of our health and happiness, the Physician.

I am not a pessimist or chronic grouch and only mention these things just to remind us that —united we stand, divided we fall.

When each of us graduated in medicine and entered the field of active practice, we enlisted for life. We compose an army to fight for the perpetuation of the human race, and to establish health and happiness for all mankind, rich or poor, king or denizen of the underworld.

To this end we are bound together by the oath of Hippocrates. Let us add to this oath the admonition of Our Savior, "Love one another."

Let us recognize the fact that our fellow practitioners are our friends, not our enemies. Do not believe the tales and falsehoods that may be told you by some long tongued man or woman; but, instead, let's gird ourselves in such armour that we shall be prepared against any attack from any source and shall be glad to say, yes, in reality, "I am my brother's keeper."

Check and Double-Check.

Organized Medicine and The Future

By DR. CHARLES W. PATTERSON
Rosedale, Miss.

When I think of the recent meetings of the medical societies in this state and the number of times that Organized Medicine has been placed upon the menu as a mental diet and stimulus for the development and growth of our association, it causes me great trepidation to serve you the same savory mixture even thought garnished with the sauce of future. If I felt assured that such a dish of facts could purge you of self satisfaction and enrich your soil of sluggish energy for the germination of renewed activity, then I could freely clear the old table of thought for the new possibilities of which I am about to bring you.

While we linger in the dinning room of contentment feasting upon the past scientific facts brought to us by those great martyrs of medical research, many of our brothers can be seen passing through the door of single action into that world of selfishness where brains atrophy into a visual narrowness. Let each member of this society take the oath of allegiance to the cause of organization and rush forth into the highways and byways of human traffic with the endless cable of combined thought to search for those wayward sons of medicine and, if found, lead them into the kitchen of action, there to be fed from the stew pot of broadness steaming with those transforming vitamines of new methods. We must perform this Herculean task today, or face that medical cupboard with its bare shelves of future progress and see the once proud and growing profession starve and shrink into a lowly business, where dollar is honor, might is right and life is strife.

My opinion, based on observation of your past good work, is that you iron nerved men of super determination and perservance could not be forced to swallow food poisoned with failure. Being thus encouraged, I will mention this thought which occurred to me while lost in the desert of despair and thirsting for new members. "He who toils beneath the tree of time shall pluck the fruit of experience." With those toilers around the mixing bowl of experiments,, I can see that raw wisdom being drawn from many cranial lockers and mixed into the dough of knowledge for a cake of new discovery.

If, after retiring to the ante-room of our dotage, we could gaze upon the future generations and see them feasting from the table of organized thought set with the products of our great deeds and served in courses of an appetizing cocktail of scientific Small Pox Vaccine and a plate filled with cause and prevention for Measles, Chicken Pox, Cancer and Pellagra, followed by a dessert of public opinion against State Medicine then, we could well say; "I have fought a good fight, I have finished my course, I have kept the faith."

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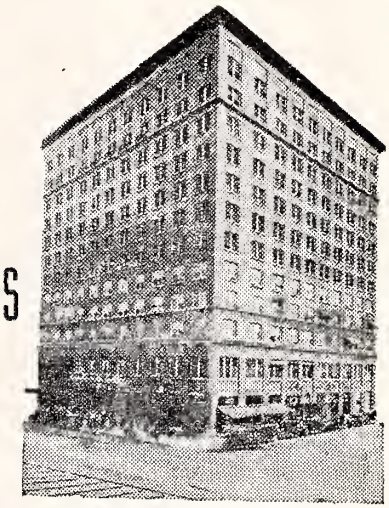

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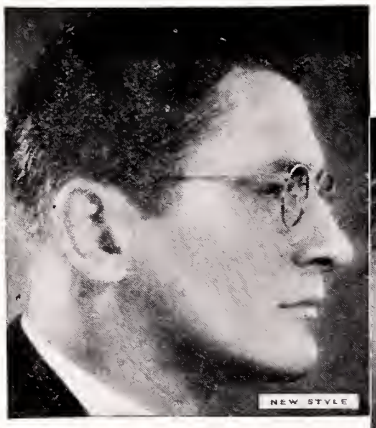

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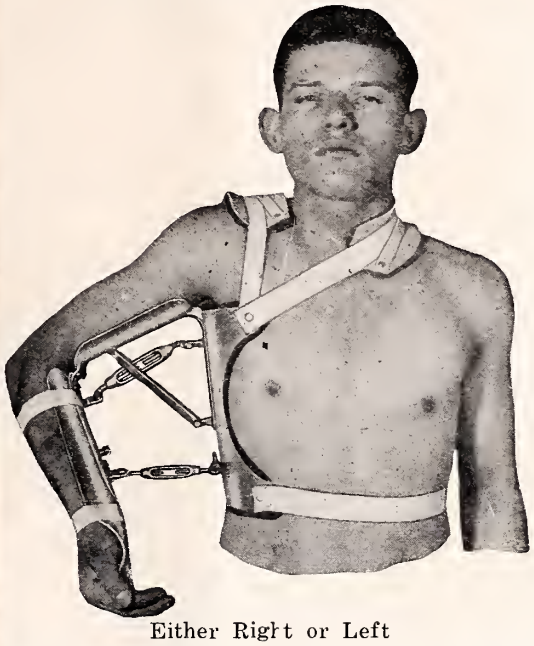


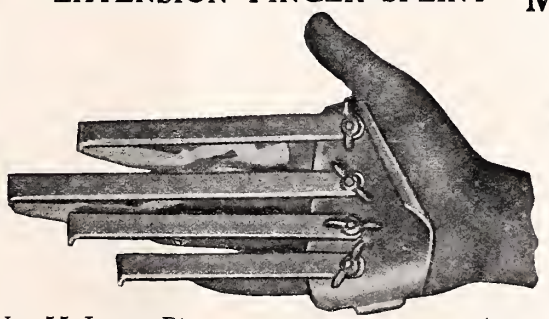
Either Right or Left

No. 41 Adult	$11.00
No. 42 Medium	11.00
No. 43 Child	10.00
Set of 3 Sizes	30.00

FOREARM SPLINT

1F, Adult Rt.	$1.00	5F, Child Rt.	.50
2F, Adults Lt.	1.00	6F, Child Lt.	.50
3F, Medium Rt.	.75	7F, Infant Rt.	.50
4F, Medium	.75	8F, Infant Lt.	.50
Complete Set of 8			$5.00

EXTENSION FINGER SPLINT



No. 55 Large Rt.	$2.00
No. 56 Large Lt.	2.00
No. 57 Medium Rt.	2.00
No. 58 Medium Lt.	2.00
Complete Set of 4	7.50

We make a complete line of X-Ray Splints

—:o:—

Write for Catalog on those not shown

—:o:—

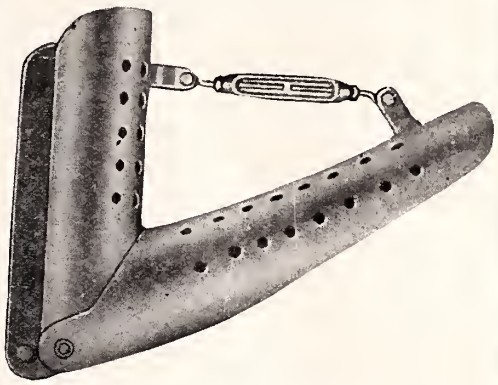
Manufactured by

Southern Splint Company

265 S. Pauline

Memphis Tennessee

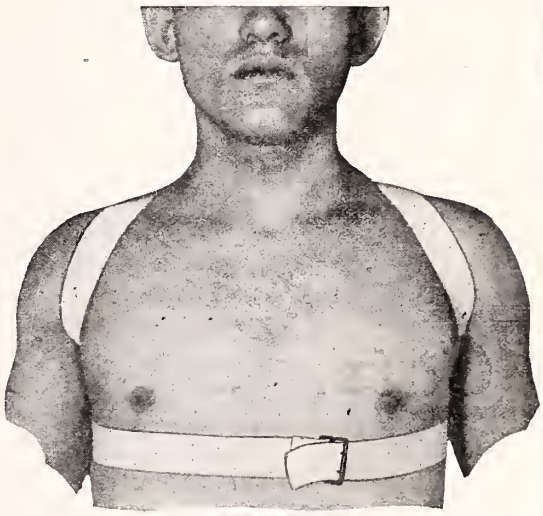
ANTERIOR ADJUSTABLE ELBOW SPLINT

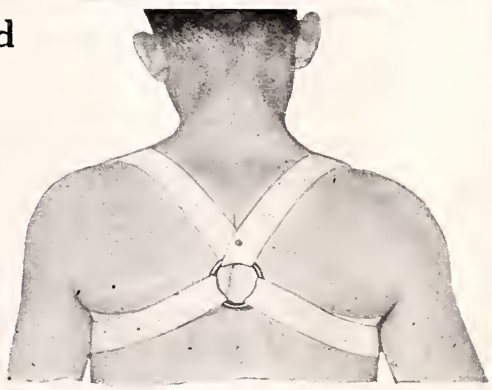


Either Right or Left

No. 19. Adult	$ 3.00
No. 20 Medium	2.50
No. 21 Child	2.50
No. 22 Infant	2.50
Complete Set of 4 Sizes	10.00

COMBINATION SHOULDER BRACE & CLAVICLE SPLINT





Made of strap webbing. Complete with shoulder pads.

No. 70 Adult	$2.00	No. 72 Child	2.00
No. 71 Medium	2.00	Set of 3 Sizes	5.00

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Staff	A trained staff of physicians, all members of the American Medical Association.

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